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ABSTRACT

This Congressional report found that today's social and economic conditions harm large numbers of American families in ways that the child welfare, mental health, and juvenile justice systems were not created and are ill-prepared to address. The following findings are reported: (1) the number of children placed outside of their homes during the 1980s increased dramatically; (2) the number of children experiencing repeat placements in foster care is increasing; (3) younger children are entering out-of-home placement at an increasing rate; (4) minority group children are disproportionately represented among children placed out-of-home; (5) drug and alcohol abuse contribute substantially to increased out-of-home placements; (6) deteriorating social conditions, including child abuse and homelessness, jeopardize child safety and fuel the child placement explosion; (7) existing child services are overwhelmed; (8) effective services for children and families in crisis have been impeded by lack of Federal leadership, funding, and oversight; and (9) prevention and early intervention programs show great program benefits and cost effectiveness. Dissenters question the statistical data upon which the projected increase in the number of children requiring foster care are based. Statistical data are included on seven charts. The following material is appended: (1) statistical data on 13 tables; (2) a list of 177 references; (3) a copy of a state survey questionnaire about children in substitute care; (4) a list of Federal programs affecting children in state care; (5) a list of state-by-state litigation on behalf of children in state care; (6) the results of a survey on addicted infants and their mothers; (7) additional views; and (8) dissenting views. (FMW)

| 101st Congress<br>*2d Session* | HOUSE OF REPRESENTATIVES | Report<br>101-395 |
|---|---|---|

ED322268

# NO PLACE TO CALL HOME: DISCARDED CHILDREN IN AMERICA

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## A REPORT

together with

ADDITIONAL and DISSENTING VIEWS

OF THE

## SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

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January 12, 1990

The Honorable Donnald K. Anderson
Clerk
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Anderson:

We are pleased to transmit the enclosed report entitled "No Place to Call Home: Discarded Children in America."

This report, which is transmitted in accordance with Title II, Section 206(a) of House Resolution 84, provides a comprehensive analysis of conditions in the nation's child welfare, mental health and juvenile justice systems. It reviews the changes which have occurred in the past decade for children and families involved with these systems. And, in addition to incorporating new data collected by the Select Committee and national projections for out-of-home placements in the 1990s, the report identifies promising programs to prevent unnecessary placement of children away from their families.

Respectfully submitted.

Sincerely,

George Miller

GEORGE MILLER
Chairman

Enclosure

# NO PLACE TO CALL HOME:
# DISCARDED CHILDREN IN AMERICA

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101st Congress
2d Session
HOUSE OF REPRESENTATIVES
Report
101-395

# NO PLACE TO CALL HOME: DISCARDED CHILDREN IN AMERICA

January 12, 1990.—Pursuant to section 206 of H. Res. 84, referred to the Committees on Education and Labor, Energy and Commerce, the Judiciary, and Ways and Means and ordered to be printed

Mr. **Miller** of California, from the Select Committee on Children, Youth, and Families, submitted the following

## REPORT

### FOREWORD

Nearly a decade ago, Congress enacted legislation to guarantee support for children in troubled families. This support would take place first in their homes and in their communities. If removing children from their homes became necessary, Congress assured them high quality services with the hope of reestablishing them later with their families. If reunification were not possible, the law included a commitment to find them permanent homes.

The Select Committee on Children, Youth, and Families set out to determine if this goal is being met. Through a series of hearings, some held jointly with the Committee on Ways and Means, we sought answers to many questions:

- Are there fewer unnecessary placements of children out of their homes?
- When children must be placed, are there more effective permanent placements than there were ten years ago?

- Are children receiving quality services when they are entrusted to the child welfare system?

- Can troubled children and families rely on human services agencies to help them cope with the host of new and complex problems which threaten their stability?

In answering these questions, the Committee focused on the wide range of services that children and families need. These services are not the responsibility of one agency, but fall under the purview of several different systems, particularly child welfare, juvenile justice and mental health. We recognized, along with experts and program administrators, that regardless of how children enter these systems, they share common problems. Thus, our hearings, and this report, focus on how children fare in all three service systems.

Our findings are alarming.

Over and over again, witnesses describe agencies in crisis, and services that are failing families and children. The promise extended almost ten years ago has not been kept, and children are paying the price of this failure.

Chief among our findings is that today's social and economic conditions are hurting large numbers of American families in ways that our current child welfare, mental health and juvenile justice systems were not created and are ill-prepared to address. Mounting child poverty and rapid increases in child abuse reports are major contributors to the dramatic increase in placement of children outside their families. It is also impossible to ignore the devastating impact that drug and alcohol abuse are having on families, propelling children into out-of-home care at an escalating rate.

While there is little doubt that economic and social trends are fueling a collapse in children's services, we found extraordinary failings in these systems that remain within our capacity to control. Federal oversight and funding are weak to nonexistent. There are too few resources in these service systems to meet the increasingly complex needs of children. Too many of the services which do exist are uncoordinated, inefficient, and ultimately ineffective, as administrators themselves attest.

Not only have these deficiencies given rise to inadequate and potentially dangerous situations jeopardizing hundreds of thousands of children, but in too many instances, they waste money in the process. Additional burdens created by unanticipated social conditions do not relieve child services administrators and workers of their responsibility and accountability for the children and families in their charge.

This is a report "from the front" which compiles the best and most recent information available. It draws not only on expert testimony, but on the voices of parents and children themselves. In addition, because national data on children in substitute care continue to be inadequate, this analysis draws on new survey data collected by the Select Committee, and on the most up-to-date independent, university, foundation and government-sponsored research.

Our investigation has revealed some promising policies, innovative strategies and effective programs. Family preservation programs, which first came to the committee's attention during its 1986 study of child abuse*, and which provide intensive in-home services to families at imminent risk of having a child removed from home, continue to demonstrate success in keeping families together and saving public resources as well. And several states and localities are beginning to establish effective interagency responses to at-risk children and families.

As our witnesses repeatedly recommended, a bolder and more sustained redesign and redirection of services for children and families are essential. Service delivery can never keep pace with the escalating problems amply documented in this report unless they are geared to earlier, and more comprehensive, responses to families and children in need.

Our hope is that this report spurs action to fulfill the commitment made a decade ago. This will require federal leadership and oversight, as well as persistent action at the federal, state, and local levels, to reverse the assault on vulnerable children and troubled families, and to forge the opportunities and protections to which every child in our nation should be entitled.

(Signed)

GEORGE MILLER,
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[*] Abused Children in America: Victims of Official Neglect. A Report of the Select Committee on Children, Youth, and Families. U. S. House of Representatives. March 1987.

## FINDINGS

### 1. More Children Placed Outside of Their Homes

Dramatic increases in the numbers of children placed outside their homes have occurred during the decade of the 1980s, and are continuing to occur in the child welfare, juvenile justice and mental health systems:

- Nearly 500,000 children are currently estimated in out-of-home placement. If current trends continue, by 1995, that population is projected to increase by an estimated 73.4% to more than 840,000 children.
- In the child welfare system, the number of children in foster care has risen by an estimated 23% between 1985 and 1988 in contrast to a 9% decline between 1980 and 1985, according to new data collected by the Select Committee on Children, Youth, and Families.
  - There were an estimated 340,300 children in foster care in 1988, compared to 276,300 in 1985.
  - In **California**, which has one in five of the nation's children in foster care, the number of foster children increased by 44% during that period; in **Michigan** by 34%; in **New York** by 29%; and in **Illinois** by 19%. By contrast, in **New Jersey** and **North Carolina**, the number of foster children declined by 5% and 7% respectively.
- In the juvenile justice system, the number of youth held in public and private juvenile facilities in 1987 had increased by 27% since 1979, 10% between 1985-87 alone. There were 91,646 juveniles in custody in 1987, compared with 83,402 in 1985 and 71,922 in 1979. In 1987, 353 juveniles per 100,000

were in custody compared with 313 per 100,000 in 1985 and 251 per 100,000 in 1979, a 41% increase in custody rates during this decade.

- In the mental health system, there was a 60% increase in the number of children under 18 in care as inpatients in hospitals, in residential treatment centers or in other residential care settings between 1983 and 1986. At the end of 1986, 54,716 children were in care, compared with 34,068 in 1983.

## 2. More Children Experience Repeat Placements

- Between 1983 and 1985, the number of children placed in foster care more than once nearly doubled, from 16% to 30%.

- There has been no significant progress in reducing the average length of stay of children in foster care. In 1985, the percentage of children in care more than 2 years stood at 39%, relatively unchanged from 1983.

## 3. Younger Children Entering Out-of-Home Placement At Increasing Rate

- In 1988, a greater proportion -- 42% -- of the children who entered foster care were under six years old, compared with those who entered in 1985 (37%), according to a Select Committee survey.

  ** In **Missouri**, nearly one out of every two children entering the Division of Family Services placement system is between birth and six years of age.

## 4. Minority Children Disproportionately Represented

- While the majority of children in foster care is white, in 1985, minority children comprised 41% of the children in foster care; by 1988, that proportion is estimated to have increased to approximately 46% -- more than twice the proportion of minority children in the nation's child population.

- The median length of stay for black children in care is one-third longer than the national median, according to a recent study of 1,000 black children in care.

## 5. Drug and Alcohol Abuse Contribute Substantially to Increased Out-of-Home Placements

- The number of infants born drug-exposed -- an estimated 375,000 nationwide in 1988 -- has nearly quadrupled in the last three years in hospitals across the country. Many of these children are abandoned or neglected, often becoming "boarder babies" in hospitals, or foster children.

- State and local child services systems report the serious impact of substance abuse on their caseloads:

    - **New York:** In 1988, crack use was identified in nearly 9,000 cases of child neglect, over three times the number of such cases in 1986;

    - **District of Columbia:** more than 80% of the reported cases of child abuse and neglect involved substance abuse;

    - **Florida:** 33% of all reported cases of child abuse were substance-abuse-related;

- ** **California:** up to 60% of drug-exposed infants have been placed in foster care;

- ** **Illinois:** the number of infants requiring placement out of home for substance-abuse-related reasons totalled 1,223 in 1988, a 132% increase over 1987.

## 6. Other Deteriorating Social Conditions Jeopardize Child Safety, Fuel Child Placement Explosion

- * Between 1981-1988, reports of abused or neglected children rose 82%, reaching 2.2 million. In 1988, deaths from child abuse exceeded 1,200 -- more than a 36% increase since 1985.

- * The U.S. Conference of Mayors reports an 18% increase in requests for shelter by homeless families between 1987 and 1988. Many cities cannot accommodate homeless families with children, resulting in family break-up and the entry of children into substitute care. Homelessness was a factor in over 40% of the placements into foster care in **New Jersey** in 1986, and in 18% of the placements, it was the sole precipitating cause of placement.

## 7. Child Services Systems Overwhelmed

- * An estimated 70-80% of emotionally disturbed children get inappropriate mental health services or no services at all.

- * Foster family homes -- for decades the mainstay of out-of-home care resources -- are far too few to meet the demand. In **California** between 1986 and 1988, the number of foster family homes increased by 11%, while the number of foster children increased by 28%.

- Excessive caseloads overburden the systems' ability to provide minimal care and appropriate services.
    - In **Los Angeles**, the average foster care worker caseload in 1988 was between 75 and 78 children.
    - In **California**, juvenile probation officers carried average caseloads of between 65 and 80.
    - In large urban areas, one judge may hear as many as 100 abuse and neglect proceedings a day.
    - As of September 1989, the **District of Columbia's** child welfare system had not completed investigations on a reported backlog of more than 700 cases involving some 1,200 children.
- In 1985, adoption was the goal for approximately 36,000 of the 276,300 children in foster care; more than 16,000 were awaiting adoption; and 79% of them had been waiting more than six months.

## 8. Failures of Federal Leadership, Funding and Oversight Impede Effective Services for Children and Families in Crisis

- Despite soaring increases in the number of children in state care, federal funding has not kept pace:
    - Funding for child welfare services that provide prevention and reunification support has not yet reached the 1980 authorized level of $266 million.
    - While the number of youth in juvenile facilities increased 27% between 1979 and

1987, funding for the federal Juvenile Justice and Delinquency Prevention Act has declined from $100 million in 1979 to $70 million in 1981, to $66.7 million in 1989.

** Despite new data demonstrating that millions of children need mental health services, the principal federal support for mental health services, the Alcohol, Drug Abuse and Mental Health Block Grant, provided $503 million in FY 1989, $17 million less than the sum of the categorical programs prior to consolidation into the Block Grant in 1981. There is no separate funding for children's mental health services, and only since 1988 has 10% of the mental health share of the Block Grant been set aside for community-based mental health services for seriously disturbed children and youth.

** Federal reimbursements to the states under Title IV-E of the Social Security Act (foster care maintenance program) have grown from $546.2 million in 1985 to $891 million in 1988. States have expanded permanency planning services and claimed federal funds more thoroughly under federal law and regulations to serve an estimated 122,949 children who were in IV-E foster care in 1988, up 17% from 1981, and up 13% from 1985. While states have utilized changes in definitions to claim additional federal support, the definitions in the law do not provide for precise accounting about the use of these monies.

Funding mechanisms create disincentives to keeping families together and maintaining children in the community. For example:

  - ** Open-ended federal matching funding is provided to the states for expenditures under the Title IV-E foster care maintenance program at an average of 53% of eligible costs; only very limited funding is available for placement prevention and family preservation.

  - ** In **Minnesota**, the mandatory mental health and chemical dependency health insurance laws provide financial incentives favoring inpatient over outpatient care.

- * Weak federal monitoring and oversight have undermined implementation of protections and services under P.L. 96-272, the Adoption Assistance and Child Welfare Act of 1980. The Department of Health and Human Services (DHHS) fails to monitor the requirement to make "reasonable efforts" to prevent the need for placement and to make it possible for a child to return home, and fails to assess whether states' Title IV-B child welfare services programs are adequate to meet the needs of the children and families served. The Office of Juvenile Justice and Delinquency Prevention conducts little monitoring of state activity under the juvenile justice law.

- * There are no complete and accurate national data on children in publicly-funded substitute care. This seriously compromises planning and service delivery by the states and the federal government.

### 9. Prevention and Early Intervention Programs Show Great Program Benefits and Cost Effectiveness

- * Family preservation programs which provide intensive in-home services to families at risk of having a child removed have demonstrated success:

** In family preservation programs in **Washington** and **Utah**, 68% of children who received services remained in their own homes or with relatives. By contrast, 69% of children who did not receive services were placed out-of-home.

** Only 2% of the families served under **Maryland's** Intensive Family Services' program required out-of-home placement, at an estimated cost saving of $6,174 in averted foster care costs per child.

** In **Virginia's** family preservation effort, only 7% of participating families during 1986 experienced placement; 69% showed improved family functioning; the intervention cost $1,214 per child compared with $11,173 for foster care and $22,025 for residential care.

* Administrators, providers and advocates agree that future help for children must reverse current funding patterns, provide earlier support for both children and their families, and forge a comprehensive service system that responds to individual needs.

# CHAPTER I. CHILDREN AND FAMILIES IN CRISIS

> When I was younger, I was in foster care for a long time. I went in and out of foster care a lot of times. I was in so many foster homes I can't remember them all....It was terrible to be put in lots of different homes with lots of strangers, knowing they wouldn't let me be with my mother. I wanted to be with my mother and my brothers and sister....I had a lot of social workers. I had so many I can't remember them all....Because I've lived so many different places, I've also been in lots of different schools. I want to do well in school but all this moving around has made it very hard for me to keep up with my class....My mother used to come to visit me a lot when I was in care and when she left, it felt like the whole world was leaving me. It was so hard that sometimes I almost didn't want her to visit because it hurt so much.
>
> (Boyd A., age 12, 4/88, with Lowry)

> Joshua, who retreated into his own world at age 2 upon the death of his father, was diagnosed as severely depressed, with autistic tendencies. At age 5, he was diagnosed as hyperactive and learning disabled; at age 10, he was hospitalized for destructive behavior. Due to a lack of specialized support services, therapeutic and residential placements in his community, Joshua's mother relinquished custody of him when he was 13, so he could receive services through the child welfare system.
>
> (Glenda Fine, Parents Involved Network Project, Mental Health Association of Southeastern Pennsylvania, 7/87)

> James was a disturbed 12-year-old whose mother repeatedly tried but was unable to obtain help for him. Diagnosed as hyperactive when he was young, he evidenced many behavior problems particularly in school. As James grew older, his mother reported that she sought help from juvenile services but was told that 'there isn't anything we can do for you.... They said, well, because son has never been in trouble....And that was the whole thing, they weren't going to do anything until he got in trouble.' Eventually he was arrested for trespassing and ended up in juvenile detention. While there, he was abused and eventually committed suicide.
>
> (Judy Guttridge, James' mother, 9/86)

These are only three children from among the hundreds of thousands of youngsters in children's services systems, but the struggles they and their families faced to obtain help are not uncommon. These children are frequently in contact with multiple agencies but all too often, whether in placement or not, they do not receive the help they need in a timely and effective manner.

Many children experience multiple placements by moving from one child placement system to another. One witness before the Committee noted that many of the children who commit crimes and end up in juvenile facilities have been raised in the child welfare system and characterized that system as "a government-funded incubator of youthful offenders." (120)

## A. More Children in Out-of-Home Care

### 1. Foster care, juvenile justice and mental health placements are growing rapidly

Three systems have had principal responsibility for children who require care out of home. The foster care and child welfare system is responsible for children whose parents have been unavailable or unable to care for them. Youth who commit delinquent or criminal acts are generally placed in the juvenile justice system. Children with serious mental health problems may be placed in institutions, many of them public state hospitals. While viewed as having separate and distinct functions and responsibilities, foster care, juvenile justice and mental health agencies increasingly recognize that the children in their care have similar problems even though they may enter substitute care through different routes.

The numbers of children entering all forms of care are increasing dramatically.

Overall, approximately half a million children are in out-of-home placement. Based on current trends, and if there are no major policy changes, it is anticipated that by 1995, this population will have increased by 73.4% to 850,000 children.[1]

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[1] Projections to 1995 were calculated by the Select Committee with assistance of Dr. Charles Gershenson, Center for the Study of Social Policy, using linear forecasting based on the most recent and comparable experiences for which data are available. Data from 1985-1988 were used to make projections for the child welfare system. For juvenile justice, two estimates were made: one using data over the period 1979-1987; the other, utilizing data from 1985-1987. Data on children with serious emotional problems were from 1983 and 1986. Calculations indicate that there would be 553,600 children in the foster care/child welfare system (representing an increase of 7.2% compounded annually); 119,700-130,000 in custody in the juvenile justice system [3.4%-4.5% compounded annually (range endpoints reflect projections using 1979-87 and 1985-87 databases respectively)]; and 123,000 in out-of-home placement for emotional problems (17% compounded annually). The overall projection sums the projection for each system, utilizing the more conservative estimate for juvenile justice.

### a. Foster Care

New data collected by the Select Committee on Children, Youth, and Families indicate that there are more children in care today than before passage of P.L. 96-272. (See Table 1) In 1980, the foster care population numbered approximately 302,000.[2] That number reportedly dropped to 267,000 in 1982 and was reported at 269,000 in 1983 for the 50 states and the District of Columbia. The most recently published national survey reported more than 276,000 children in foster care at the end of 1985, and experts consider that count conservative.[3,4]

By all accounts, since 1985 the placement rate has surged. To determine the extent of this increase, the Select Committee conducted a telephone survey of the 10 most populous states to obtain the most recent data on the number of children in substitute care. The states surveyed were California, Florida, Illinois, Michigan, New Jersey, New York, North Carolina, Ohio, Pennsylvania and Texas. (Together these states accounted for 52% of the total 1980 foster care population and 51% of the

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[2] National estimate for 1980 does not include Puerto Rico. Inclusion of data from Puerto Rico brings total to 303,500. 1980 data were obtained from Office for Civil Rights, U.S. DHHS, Children and Youth Referral Survey: Public Welfare and Social Service Agencies, 1981.

[3] The data are voluntarily submitted by the states to the American Public Welfare Association and reported by DHHS after analysis by a private contractor. 1982 was the first year of data reporting under P.L. 96-272, the 1980 reform law. Data before 1985 should be viewed with some caution; data from 1985 and after are more reliable, complete, and free of much of the duplicated counts in earlier data. Reported data have the following problems that suggest an undercount: not all the states submit data as requested and states differ in the ways they define the children in care who should be counted; the data also do not include several thousand Indian children in foster care in the custody of the Bureau of Indian Affairs or in private programs.

[4] 1985 data include Puerto Rico.

1985 foster care population.) (See Appendix III for a copy of the survey) Recent available data for Missouri, the 15th most populous state, were also included in calculating estimates of the total foster care population, bringing the proportion of the total foster care population that was accounted for to 54%.[5]

The 10 surveyed states were variously able to respond to the Committee's request for information. All provided some data on the numbers of children in care through 1988. Nine of the 10 were able to report data by age, race, time in care and/or outcome for one or more years after 1985.

Based on this survey, the Committee estimates that approximately 340,300 children were in foster care at any point in 1988, representing an increase of 23% since 1985, in dramatic contrast to the 9% decline seen from 1980 to 1985. (See Chart 1)

The increase in the number of children in foster care is due to a greater rate of increase in children entering care as compared with children leaving foster care. In the past three years, based on the states able to report, the number of children entering foster care each year has increased by 27%. By contrast, children are leaving foster care in 1988 at a rate that is only 4% higher than that in 1985. There is also evidence emerging from state and local studies indicating that the median length of stay of children in the child welfare system is on the rise again. (See Table 2) (123, 176)

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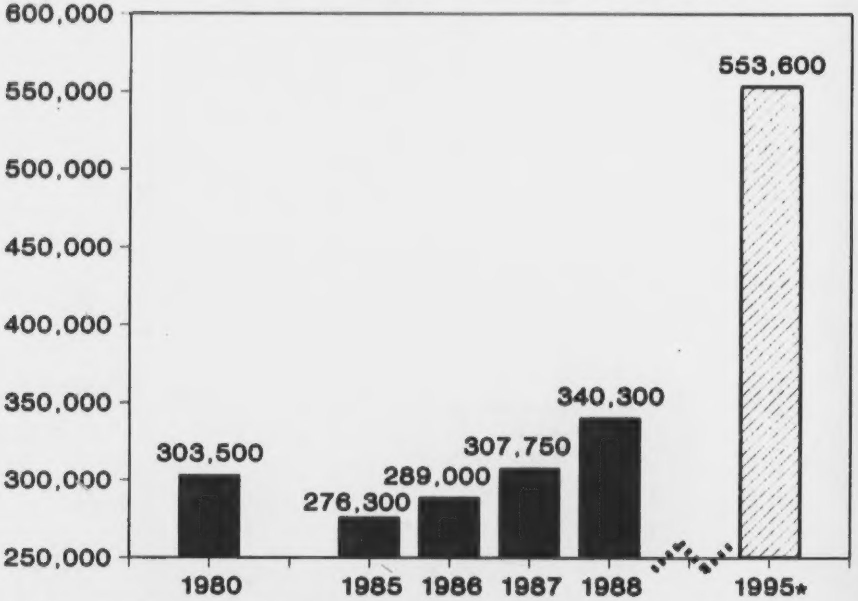
[5] Data for Missouri were obtained from the report, Where's My Home?, Citizens for Missouri's Children, January, 1989.

Chart 1

## Foster Care Trends in the U.S.

### 1980, 1985-1988, and 1995 Projected



Source: 1980, 1985-1988 data, see Table 1 notes.
*1995 projection based on current trend; see Footnote 1, Chapt. I.

### b. Juvenile Justice

Youth in public and private youth facilities in 1987 totaled 91,646, up 10% from 83,402 in 1985 and 27% from 71,922 in 1979. (129, 132) The number of juveniles held in publicly run facilities in 1987 totalled 53,503, the highest number since the Department of Justice conducted the first Children In Custody census in 1971, representing a 8% increase over 1985, and a 24% increase since 1979. The number of youth in private facilities was 38,143 in 1987, up 12% from 1985, and 33% from 1979. (See Chart 2 and Table 3)

Of these children, more than 35,000 individuals were confined in long-term, public juvenile institutions, the majority of which are state-operated. Approximately 60% of the juveniles and young adults in these long-term institutions were between the ages of 15 and 17; 12% were younger and 27% were older.[6] (166)

Moreover, the declining population of youth during these years along with the increase in the number of youth in custody has meant that a greater proportion of the youth population was in custody. The 1987 youth in custody population represents some 353 youths per 100,000 juveniles in the population, an increase of 41% from 251 juveniles per 100,000 in 1979 and 313 per 100,000 in 1985. (129) In public facilities in 1987, 208 juveniles per 100,000 were in custody, compared with 151 per 100,000 in 1979 and 185 per 100,000 in 1985. The youth in public facilities constitute about two-thirds of the more than 90,000 juveniles in custody and cared for in public and private facilities nationwide. (166, 129)

Corresponding growth has occurred in the number of public and private facilities housing children served by the juvenile justice system. The census found that states or local government agencies operated 1,107 facilities in 1987, or 9% more than they operated in 1979 and 6% more than 1985. The

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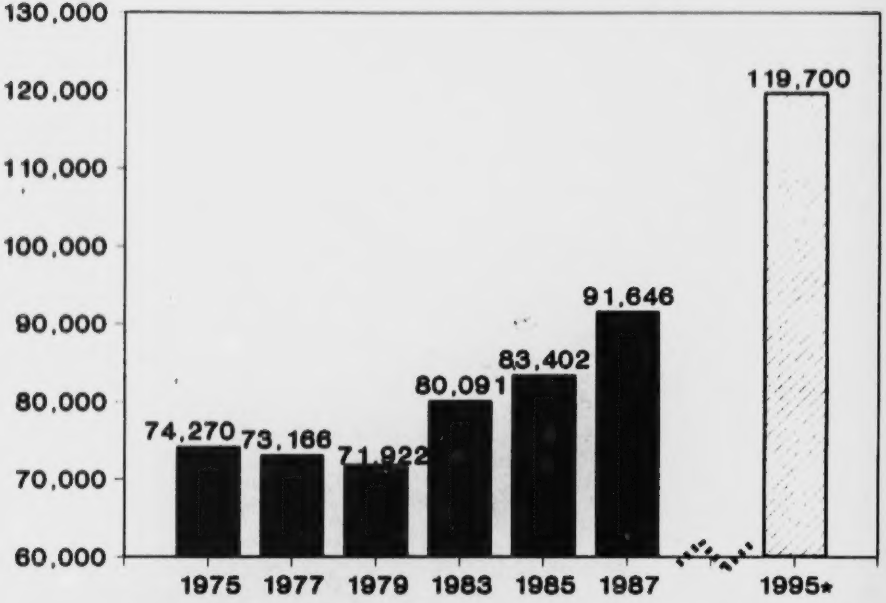
[6] These numbers reflect one-day counts; many more youths go through these facilities during the course of a year.

Chart 2

## Total Juveniles in Custody

### 1975-1987, and 1995 Projected



Source 1975-1987 data. See Table 3 notes.
*1995 projection based on current trend; see Footnote 1, Chapt. I.

number of private facilities grew from 1,561 in 1979 to 1,996 in 1985 and 2,195 in 1987.

### c. Mental Health

The number of children in placement as a result of emotional problems also has risen dramatically over the last few years. According to the end-of-year census conducted by the National Institute of Mental Health, in 1983 there were 34,060 children under 18 in care as inpatients in hospitals, in a residential treatment center or other residential care setting. The count at the end of 1986 had increased more than 60% to 54,716. (See Chart 3 and Table 4)

Over a year period, the total number of children in such facilities is much higher, approximately 100,000 children. In addition, about 2 million children receive mental health treatment in out-patient settings. (133)

These children represent only a fraction of the 7.5 million American children who are believed to suffer from a mental health problem severe enough to require mental health treatment. (133)

The impact of these dramatic increases in the numbers of children in placement, regardless of the system, can be seen even more clearly by focusing on reports from specific states and communities.

**California** There are increasing numbers of children entering shelter care....The number of children in shelter care, as reflected by the average monthly census in the 11 counties, has increased 83% between 1983 and 1987. (28)

In California today, there are 9,000 children placed out of home in intensive residential treatment facilities. The cost is $220 million a year, and that rate is growing at 20% per year. That is only for the most intensive residential programming. It doesn't count the less intensive foster care system.

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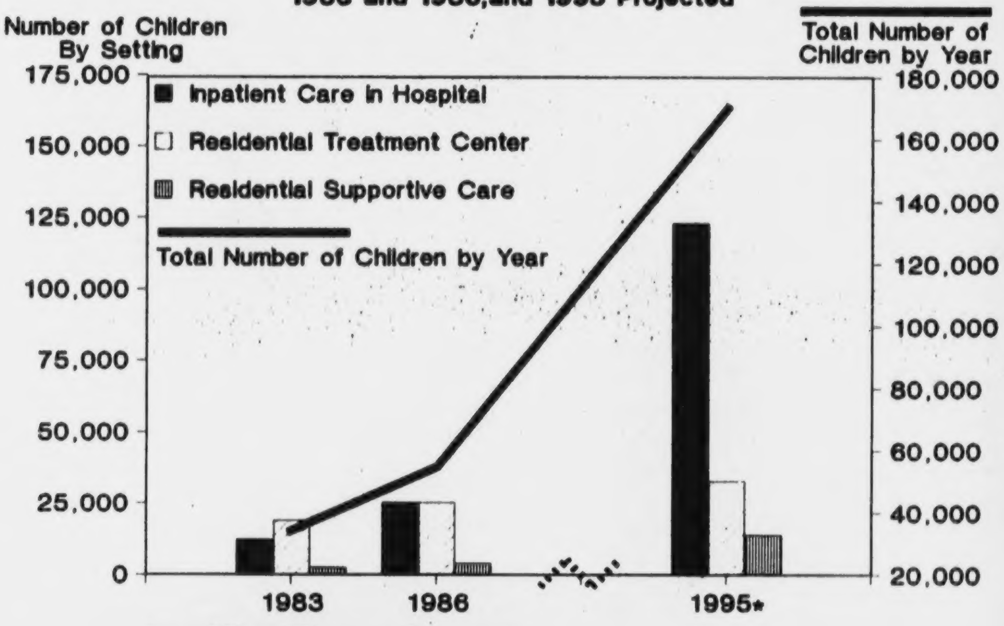
Chart 5

## Children in Out-of-Home Placement for Emotional Problems

### 1983 and 1986,and 1995 Projected



Source: 1983 and 1986 data, see Table 4 notes.
*1995 projection based on current trend; see Footnote 1, Chapt. I.

(79, emphasis added)

**New York** In 1987, the Juvenile Rights Division represented approximately 30,000 children in New York City's family courts, including over 16,000 who were the subject of abuse and neglect cases. In 1986, we represented 9,800 such children, a 66.5% increase in only one year. This dramatic one-year growth follows an unprecedented 197% rise in our [NYC] child protective caseload between 1983 and 1986. (36, emphasis added)

**Philadelphia, PA** In 1982, in the City of Philadelphia, there were less than 200 emergency room visits by children and adolescents, psychiatric visits. In 1987, five years later, the figure is expected to exceed 1,000. That is a 500% increase in five years. On any given day in Philadelphia, there are 2 to 15 youngsters awaiting a hospital bed which is not available for them. (82, emphasis added)

These rapid increases in state and local caseloads are overwhelming the agencies designed to protect and provide services to children and families in crisis and are causing serious problems in the operation and effectiveness of state and local programs. (See Chapter II)

2. Repeat placements are increasing

Many children in out-of-home placements have spent time in care before. A recent examination of children in foster care in New York State in 1984 and 1985 found that 21%, or 1 out of 5 children, were re-entering the system. (139)

National data on re-entry into foster care suggests a significant increase in children entering substitute care more than once. Thirty percent of children placed in 1985 had previously been in care, up from an estimated 16% in 1983, according to reports through the Voluntary Cooperative Information System

(VCIS).[7] The states surveyed by the Select Committee were unable to provide more recent and reliable information on reentry into care.

This trend was confirmed by the state and local experience shared by witnesses before the Committee. In a New Jersey program, 50% of the families had prior placement histories (121); in Baltimore City, nearly a quarter of the children had been in foster care before. (44) And, according to Children's Research Institute of California, one-third of the children entering emergency shelter care in the state are "repeat" placements. (28)

3. Child abuse and neglect, substance abuse, homelessness, poverty and changing family demographics are driving these placements

> Since 1980, escalating rates of child poverty, growing numbers of births to unmarried teens, skyrocketing numbers of homeless families, growing substance abuse, a ninety percent rise in reports of abuse and neglect and now the deadly threat of AIDS -- all interrelated problems -- have placed increasing stresses on families and new demands on the system, jeopardizing its ability to serve appropriately children in need. Over a decade ago we were not even considering the impact of such problems on the child welfare system. (1)

The constellation of problems cited in this testimony have created situations that more and more families find almost impossible to handle.

More children and their families are now living in precarious economic circumstances. Nearly three million more U.S. children fell into poverty over the last decade and today, one in five children (13 million) lives in poverty. (165) In addition, between 1970 and 1985, the real median family income of families with children declined 5.8%, and while real family income rose between 1985 and 1987, it remains below the 1970 level. For those families falling in the bottom fifth of the income distribution, average family income declined 14% between 1979 and 1987. (172, 168, 173) Frequent unemployment and underemployment, as evidenced by persistent "high joblessness rates among teenagers and young adults, especially blacks and other minorities," add further to the constellation of pressures that affect the children and families served by the child welfare system. (4, 1, 105)

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[7] Only 15 states reported relevant information in 1985, and there are wide variations in definitions and data collection strategies among the states.

Changing family demographics have also profoundly affected children's living situations. For example, while one in 10 children lived with only one parent in 1960, currently nearly one in four lives in a single-parent family. (150) Between 1970 and 1988, the percentage of children with working mothers has increased by 54%. (See Select Committee on Children, Youth, and Families hearings and reports for fuller description of demographic shifts; notably U.S. Children and Their Families: Current Conditions and Recent Trends, 1989 and Children and Families: Key Trends in the 1980s, 1988, among others.)

These economic and demographic changes provide the context in which the problems which bring families and children into the substitute care systems are increasing.

### a. Child Abuse and Neglect

Perhaps the major problem fueling the increasing numbers of children in care has been the rapid growth in the numbers of children reported as abused and neglected. A 1988 Department of Health and Human Services report, "Study of National Incidence and Prevalence of Child Abuse and Neglect," documented a 64% increase over 1980 in the number of children reported, and using a revised definition agreed upon by experts in the field, a 150% increase in actual child abuse and neglect victims. (163) This report is consistent with the findings of the Select Committee's 1986 study on child abuse that documented a 55% increase in reports of abuse and neglect between 1981 and 1985 (See Table 6) and the more than 11% average annual increase during the first half of the decade noted by the American Association for Protecting Children. (124)

The absolute number of reports behind these percentages is very large. (46) There were 2.2 million reports of maltreatment filed in 1988, according to the National Committee for the Prevention of Child Abuse. (See Table 5) This represents an increase of 82% from the 1.2 million children reports recorded for 1981 by the American Humane Association (122), and a 17% increase above the number of reports recorded by the Select Committee in its 1986 study of child protective and child welfare services. (See Table 6) (124)

Testimony in 1987 from the Secretary of the Maryland Department of Human Resources reflects similar dramatic and disturbing trends:

> Maryland, like most states, has seen a dramatic and sustained escalation in reports of child maltreatment. Over the past 18 months, child abuse and neglect reports in Maryland have increased by 27%, and our analysis of the data indicates that the rate of growth is likely to be even greater in the future. Some who hear these numbers seek comfort in the idea that publicity engenders reports but these reports don't reflect "real" abuse or neglect. We know otherwise, for the proportion of reports that are substantiated has remained the same....Another trend, which is important to understand, is that more and more of these reports reflect sexual abuse. (77)

This pattern recurs in other states. The Director of the Hennepin County, Minnesota, Department of Community Services told the Committee that the state continues to experience a rise in the number of reports of child abuse and neglect and that staff are seeing more and more children whose safety at home is jeopardized. (116)

Dr. Frederick Green, M.D., president of the National Committee for the Prevention of Child Abuse (NCPCA), told the Select Committee that a NCPCA survey showed that for 24 states able to report the number of confirmed or suspected deaths due to maltreatment for 1986, the number of child deaths rose 29% compared to the experiences of these states during 1985. He noted that this finding was in stark contrast to the change noted in those states between 1984 and 1985, when the number of child deaths declined by 2%.... (46)

Reported child abuse fatalities rose 5% from 1987 to 1988 to an estimated total of 1,225, according to the latest national survey conducted by the National Committee for Prevention of Child Abuse. The NCPCA estimates that this represents an increase of 36% in child fatalities since 1985. (130) For the third consecutive year, these deaths numbered in excess of 1,100. (See Table 7)

### b. Homelessness

Children in the growing numbers of homeless families are at risk of placement into substitute state care. One-third of the homeless population, estimated to number up to 2.2 million, are families with children. Estimates of the number of children in the United States who are homeless on any given night range from 50,000 to 500,000. (172) Pursuant to a mandate included in the Stewart B. McKinney Homeless Assistance Act, P.L. 100-77, the Government Accounting Office reported that an estimated 68,000 children and youth age 16 and younger may be members of families who are homeless. (134)

Among the homeless, families with children have been among the fastest growing groups. (12, 80) In New York City alone, the number of homeless families increased by 433% between 1982-1987, from 1088 to 5100. (162) The most recent Conference of Mayors' survey documented that requests for shelter by homeless families increased by 18% in 1988, and that shelters in 68% of the survey cities must turn away homeless families in need because of a lack of resources. (162) (See Table 8) Studies by the Department of Housing and Urban Development indicate that, on any given night, the proportion of shelter-using homeless who are family members has increased from 21% in 1984 to 40% in 1988. (156)

According to a new survey of several hundred public and private social agencies in 1988 and 1989, the proportion of homeless who are families may have stabilized. The survey reported that the number of homeless families with children now comprise 31% of the homeless population, and following several years of rapid growth, the number showed little or no increase. (151)

In recent years, states have reported that many of the children entering care have been homeless. In New Jersey, for example,

> Homelessness and housing-related problems have become a significant element in foster care placements in New Jersey. Homelessness is a factor in over 40% of placements into foster care; in 18% of the placements, it is the sole precipitating cause of placement. Even though these families may have experienced other problems requiring state involvement, those problems could have been treated successfully with family-based services but for the loss of housing. (121)

In a study of 1,000 Black children in foster care in five cities, inadequate housing was reported as a factor contributing to out-of-home placement of children in 30% of the study population, and as "one of the remaining barriers to reunification for 34% of the children not discharged by the end of the [approximately 2-year] study period." (176)

### c. Substance Abuse

The epidemic of drug and alcohol abuse has placed increasing numbers of vulnerable children, families and communities in crises, resulting in more reports of child abuse and neglect, and greater need for care and out-of-home placements. Substance abuse also results in increased risk of HIV infection among parents, increasing the risk of transmitting drugs or HIV infection to infants, and compounding their inability to care for their children. In New York City, for example,

> From September 1986 to November 1987 alone, the foster care caseload increased 14.1%. While the appearance of

crack on the drug scene is not the only reason for this increase, it should be noted that between FY 1986 and FY 1987, there was a 72% increase in the number of allegations involving substance abuse and a 90% increase in the number of newborns having drug or alcohol withdrawal symptoms. (89)

In California, a similar portrait is emerging:

> [In Los Angeles, the] 'children in crisis' I want to bring to your attention represent a new and growing group of high risk, special need children....I have worked with thousands of high-risk babies from birth through our infant follow-up clinics to school-age, but have never been so personally and professionally concerned and challenged as I now am regarding an increasing number of women who deliver...without any prenatal care and the large number of infants who are born with prenatal exposure to drugs. (6)
>
> [In Los Angeles] a large percentage of reported cases of infants born with positive toxicologies are removed from their mother's custody at birth or placed under supervision of the Court or Department of Children's Services because of interpretation of child abuse and endangerment laws. (6)

According to the National Committee for the Prevention of Child Abuse and Neglect, 33% of all reported cases of child abuse in the State of Florida are related to substance abuse. In the District of Columbia, almost 25% of the 6,000 cases of child abuse and neglect reported to Child and Family Services Division of the City's Department of Human Services in 1985 involved alcohol abuse and emotional problems, generally related to other forms of substance abuse. (112) By fiscal year 1988, that percentage had grown to more than 80%. (138, 130) The National Black Child Development Institute's study of black children in foster care found that drug abuse by parents was reported as a contributing factor to placement in 36% of the 1,000 cases studied. (176)

A social services director from Minnesota told the

Committee that during a 3-week period, 24 children from "crack houses were taken into protective custody...." (116)

The National Committee for the Prevention of Child Abuse also reported that

> ...in 1988, crack use was identified in over 8,521 cases of child neglect in New York, over three times the number of such cases identified in 1986. Further, over 73% of New York's neglect-related child fatalities in 1987 resulted from parental drug use; in 1985, this figure was 11%. (130)

The problems of substance abuse are increasingly pervasive, affecting children at younger and younger ages in all systems of care. As one witness told the Committee,

> Alcohol and drug abuse are appearing very early. We're seeing nine- and ten-year-old kids who are heavy drinkers and who are beginning to abuse crack. These kids are abusing everything that's on the street...they're grabbing at drugs that have as a direct toxic effect, hyperactivity and violence. These drugs, cocaine, crack, amphetamines, produce paranoia. When you come off them, they produce severe depression, every bit as severe as the kind of depressions people suffer spontaneously. They need treatment. Currently, at least 50% of the patients in our emergency room are alcohol or drug abusers, and a third of the patients in our emergency room are on crack. (64)

Increasing numbers of infants are being born drug-exposed placing them at particular risk of multiple problems that lead to out-of-home care. (20, 59) An estimated 375,000 infants were born drug-exposed in 1988. (152) A recent Select Committee survey of public and private metropolitan hospitals in 15 major U.S. cities documented the devastating impact of substance abuse-related problems for pregnant women, infants and families. The survey reported a three- to fourfold increase in perinatal drug exposure between 1985 and 1988, the severe negative effects on the health of addicted infants and their mothers, and the growing number of drug-exposed infants who are entering and staying in state care. Nearly half the hospitals surveyed reported increasing numbers of "boarder" babies who remain in hospitals because their parents abandon or cannot care for them. (See Appendix VI) (125)

In California, according to Dr. Neal Halfon who directs the Center for the Vulnerable Child in Oakland, up to 60% of drug-exposed infants have been placed in foster care. He also reported that substance abuse is involved in an increasing number of foster placements. In Alameda County, California, for example, 80% of all children under age one in foster care had a history of drug exposure. (50)

Juvenile justice agencies are seeing the same trend in drug abuse among juvenile arrestees. In its survey, Children In Custody in public juvenile facilities in 1987, the Department of Justice reported that between 1985 and 1987, the total number of juveniles held for property offenses not classified as "serious," alcohol/drug offenses, and public order violations, increased by 36%. Of those juveniles held for alcohol/drug-related offenses, 34% were charged with distribution. (129)

A witness from the District of Columbia provided further testimony to the Committee regarding this trend.

> Among children charged with a delinquent offense, we test for the presence of four drugs -- phencyclidine or PCP, cocaine, opiates, and marijuana. Fully 35% of all juvenile arrestees are currently testing positive for one or more of these drugs. There is a strong correlation between drug use and age, to the point where over half of all 17-year-olds are currently testing positive. Perhaps more disturbing than the number using drugs is the change over time. When we first began testing juveniles four years ago, less then 30% were positive, with the drug of choice being PCP. Cocaine was rarely detected. Eighteen months ago, cocaine had risen to 7% percent of all juvenile arrestees. Currently, 22% of all juveniles are showing a positive test result for cocaine -- a figure that has surpassed PCP use. More disturbing still is the fact that the numbers do not indicate that the young people

> are switching from one drug to another, rather that they are increasingly engaging in multiple drug use. They're adding cocaine to the drugs that they're already using. (17)

What emerges from this complex of disturbing trends is the pervasiveness of drugs, increasingly common among younger children and their direct impact on children's services.

### d. Youth Violence

Authorities further report that the drug trade and the nationwide spread of youth gangs involved in the drug trade have stimulated a sharp increase in the level of violence associated with juvenile crime that also brings youth into the juvenile justice system. The number of juveniles arrested for violent crime (homicide, rape, robbery, and aggravated assault) increased 9% between 1984 and 1986, after a 20% decline between 1974 and 1984. (171)

> The whole make-up of gangs has changed dramatically. It has gone from traditional turf wars and mostly street fighting to sophisticated weaponry, drug money and random killings....Gang warfare has become more sophisticated because of the ability to buy sophisticated weaponry. We now deal with automatic weapons, Uzis and gang members with grenades. They buy all this with drug money. (26)

Serious as any one of these problems is, the full impact is due to the fact that individual families and children are often affected by more than one of these problems at the same time.

## B. Children's Needs More Severe

### 1. Children in care have multiple problems

The children in care today are children who have been abused and/or neglected; children who suffer a variety of mental health problems; children who have been exposed to drugs perinatally and/or throughout their lives; children who have committed crimes or otherwise run afoul of the law; adolescents with little schooling and no job skills, pregnant teens and teens with babies; and children whose chaotic and distressed family lives due to poverty, homelessness, mental illness and a cluster of other contributig factors bring them into state care. (78, 71, 55, 15, 99, 27, 1)

Witnesses emphasized the severe mental health care needs of children in all types of care.

> An average of 32% of the children in central shelter facilities are emotionally disturbed or mentally ill. Some counties reported as many as 60% of the children in shelter care are disturbed. (28)

> Half of the emergency room visits result from suicide attempts or suicidal behavior, including children as young as nine and ten years of age....The youngsters we see are more than ever before chronically disturbed with acute symptomatology. Many seriously mentally ill young adults experience their first episode in their teens, and I think we are seeing a lot of those kids right now....(82)

In a study of over 800 seriously emotionally disturbed children served by the public sector, the Florida Mental Health Institute found that over 60% of the children received a diagnosis of conduct disorder (aggressive behavior, poor impulse control and difficulties in interpersonal relationships), more than half also were diagnosed as anxious or depressed, and many also suffer from cognitive and social skill deficiencies and family problems. (40) Similarly, a study of runaway and homeless youth in New York City found that 70-90% of these youth had serious emotional problems, and half had been abused by their parents. (158)

In the juvenile justice system, a disproportionate number of children also have a history of multiple problems, including child abuse, learning disabilities, severe emotional disturbance, school failure, behavioral disorders, and family problems.

Studies of institutionalized youth report that 26% to 55%

of juvenile offenders have official histories of child abuse. These data not only confirm the high rate of child abuse among the 'deep end' youth of juvenile justice but also provide evidence that abuse is related to serious and repetitive delinquent behavior. (3)

Juvenile justice authorities report that approximately two-thirds of the children in their system are severely emotionally disturbed. (114)

The fact that so many children have multiple needs means that traditional divisions between child welfare, juvenile justice and mental health may no longer make sense and may create barriers to appropriate services for individual children.

> ...children and families don't neatly divide themselves into social services, mental health and juvenile definitions/criteria. (55)

> ...we are talking about vulnerable, multiple-problem children. The labels that we use in the law and in our regulations do not tell you who the kids are....And what we have is a group of very uncooperative kids. We keep telling abused and neglected kids not to have any learning problems, and they keep defying us. We keep telling them to just be abused and neglected and not to have any emotional problems, and they keep coming back with serious problems. You have multiple problem kids and we have a single problem delivery system. This is not just a foster care or even social service issue. It's a mental health issue, it's a special [education] issue, and it's a juvenile justice issue.... (15)

The juvenile justice system offers another example. A large proportion of children in this system are neglected children but were not identified as such. In addition, many 'special needs' children are dumped in the delinquency system where the needed services may not be available. (38, 25)

The picture that emerges is one in which children entering state care today typically exhibit far more difficult and often multiple problems, have been in care before, and often move from one service system to another rather than returning to their families permanently.

### 2. Medically fragile infants and troubled youth constitute growing proportion of out-of-home placements

Two groups of children comprise the major new entrants into substitute care under public responsibility: one, infants and young children, many with medical complications resulting in actual or potential physical and mental limitations; two, many older children who continue through the revolving doors of state care.

In 1988, a greater proportion -- 42% -- of the children who entered foster care were under six years old, compared with those who entered in 1985 (37%), according to the Select Committee's 10-state survey. The largest change appeared in the number of very young children entering the system. (See Table 9)

The increased proportion of young children entering the foster care system is due to both demographic and social factors. Nationally, the Census Bureau estimates that this population of children will have increased by 17% between 1980 and 1990, while the adolescent population will have decreased by 14%. (173) In California, for example, the number of young children will have increased by 29% while the increase of this group entering foster care was 59% between 1984 and 1988.

Widespread substance abuse appears to be the other major factor contributing to the increasing numbers of young children entering placement.

> The increasing prevalence of cocaine and crack use has been associated with rising needs for out-of-home placements. It has emerged most dramatically in cases involving drug-addicted infants. In Illinois, the number of such infants totalled 1,223 in 1988, a 132% increase over 1987. (130)

In addition to increasing numbers of younger children entering systems of care, particularly foster care, there remains a high proportion of older children in state care.

> Over the last decade, we've been successful returning younger children to their homes more quickly; the foster care population has increasingly come to consist of older, seriously troubled children....The preponderance of teenagers in the child welfare system has produced a new set of problems: teens are much more likely than younger children to be delinquents or status offenders. Serious long-standing family problems often require out-of-home placement, but traditional foster home settings are ill-equipped to respond to their needs. Further an older child's family situation may prove so difficult to resolve that reunification can never occur. (78)
>
> In the last 10 years ending FY 85, the children entering foster care have been consistently older. All of the above factors have led to a need for increased use of residential care and the provision of other more expensive services. (57)
>
> The patients we now see are showing behavioral changes. They're more apt to present us with a long history of police and correctional contacts as well as residential treatment as well as previous psychiatric history. They are more apt to experience academic and vocational failure. They're very likely to have had an experience of a mixture of alcohol and poly drug abuse....These patients are apt to be referred by others rather than by themselves, because of impulsivity or threat of violence. (64)
>
> Children being placed for adoption are often older and 'tougher' than children who were able to be placed in the past; many of these kids have had extremely traumatic life experiences that result in on-going challenges.... (66)

A recent study of social services systems reported that the increasing numbers of older children in care also reflect many children and youth in the community "who in earlier years would have been in institutions." (160)

> One problem for this group as for comparable adults is that relatively few suitable community facilities have been established in lieu of the large institutions. (160)

As the children populating substitute care systems become increasingly older teens and very young -- often medically fragile -- infants and toddlers, the personnel, and services required to care for them will necessarily need to address their special problems.

### 3. Minority children disproportionately represented in out-of-home care

While the majority of children placed away from their homes are white, minority and low-income children are disproportionately represented in out-of-home state care.

In 1985, minority children comprised 41% of the children in foster care. (161) Based on the Select Committee's recent survey of substitute care in 10 states, the proportion of minority children entering foster care has increased slightly to 46%. (See Table 10) (125) The proportion of minority children in foster care is more than twice the proportion of minority children to the nation's child population, estimated to be about 19%. (172) These surveys also reinforce the findings of a three-state study of residential care by the General Accounting Office. In that study, nonwhite children were placed in residential care at higher rates than white children, relative to their proportions of state populations. (157)

Local communities, and even selected groups of foster children in placement, also reflect racial disparities, according to witnesses' testimony.

> Black and Hispanic children are increasingly over-represented among poor children, homeless children, drug-exposed children and children in foster care; in 1986, close to 80% of the children in foster care in NYC were black and Hispanic. In our study of 194 boarder babies

> placed with foster families in 1987, close to 95% were children of color. These numbers represent neither coincidence nor racially inherited defects. Rather, they speak to the failures of our child care and family support systems to meet the needs of minority children and families.... (80)

The increasing overrepresentation of minority children and youth is even more skewed in the juvenile justice system. The number of white juveniles held in public facilities decreased slightly between 1985 and 1987, while the number of black and Hispanic juveniles increased 15% and 20%, respectively. In 1987, 56% of the juveniles in custody were a racial and/or ethnic minority: 39% black, 15% Hispanic; 3% American Indian, Alaskan native, Asian or Pacific islander. (129)

Minority and low-income children also "stay in care significantly longer once placed, and wait longer than white children for permanent families." (78) A recent study of black children in foster care found that while the median length of stay in foster care is approximately 17 months nationally, the majority of black children whose cases were studied remained in care well over two years. (176) Older minority children are also "more likely to leave foster care for more structured, restrictive placements (including group homes, residential treatment centers, detention facilities and jail)." (78)

The growing numbers and proportions of low-income and minority children and families in the U.S. and their increasingly disproportionate representation in systems of state care compel that services must be provided for both English and non-English-speaking families, and programs must be culturally sensitive to black, Latino, Asian, and other ethnic communities. (19)

### C. Children Receiving Services Still Risk Harm

At worst, the children entering care are not helped -- and are often hurt -- by the very system that has been designed to protect them. Increasingly, many of the children who die as a result of maltreatment are known to the public service agencies charged with protecting and serving them. (41, 107, 169, 164)

Many witnesses before the Committee submitted that in the end, children may be traumatized as much or more by the failure of agencies that are supposed to help than by the problems that brought them to the attention of public child welfare agencies in the first place.

> The tragic beating death of Lisa Steinberg last fall brought media attention to the problems in protective services, but Lisa's death was not an isolated incident. It was just the tip of the iceberg....Deaths from child abuse in New York City are now occurring sometimes on a weekly basis. This past Friday, another tragedy -- a 3-year-old girl, Maya Figueroa, was allegedly beaten to death by a man who was using her to panhandle money. Maya died of blunt-force wounds to the head and stomach with internal injuries and internal bleeding. She had cigarette burns over her body. Maya was an active case in Special Services for Children. She was housed at one of New York City's 600 welfare hotels where more than 9,000 children try to live and survive. (41)

Since Spring, 1988 when the Select Committee received this testimony, the deaths of Jessica Cortez, Michael Baker and many other children have made headlines in New York City which reported 127 deaths in 1988 due to maltreatment. (137)

In Georgia in 1988, 51 children -- almost one per week -- known to the state's child welfare system died. (164)

The recent investigation by the Los Angeles Herald Examiner found that in a 17-month period, 11 children who were known to the Los Angeles' County Department of Children's Services died of child abuse.

> Social workers had met with their families and doctors had seen their bruises, but the system failed to protect them.... [In one of the cases] a social worker was too busy with other cases to visit the home of 18-month-old Brian after a doctor reported the boy's brother had been abused. Three weeks later Brian was sexually molested and beaten to death. (169)

Reports of death and serious injury have become more common for youth in juvenile facilities also.

> In juvenile correctional facilities, isolation, official neglect, abuse, and suicide of children are all too common. My colleagues and I have represented a 15-year-old girl, ordered in an Ohio jail for five days for running away from home, who was raped by a deputy jailer; children held in an Idaho jail where a 17-year-old was incarcerated for not paying a $73 in traffic fines, then was beaten to death over a 14-hour period by other inmates; and parents in Kentucky and California whose children committed suicide in jails. (107)

Soler also documented numerous abuses that occur in the mental health and residential school systems.

> In the state mental hospital in South Carolina, children who attempted to commit suicide were stripped to their underwear, bound by their ankles and wrists to the four corners of their beds, and injected with psychotropic drugs. In the Phoenix Indian High School in Arizona, Indian children found intoxicated on school grounds were handcuffed to the fence surrounding the institution and left there overnight. In a private treatment and special education facility in Utah, children were locked in closets for punishment, grabbed by the hair and thrown against walls, and given lie detector tests as part of their 'therapy'. (107)

Harm to children receiving services is not limited to the sensational tragedies of child deaths or serious physical abuse but includes a wide range of negative consequences for children over the short- and longer-term.

In the District of Columbia, for example, infants and small children remain at a frequently overpopulated institutional facility for months and sometimes years, resulting in profound and potentially irreversible developmental delays and related emotional problems. St. Elizabeth's Hospital children's and adolescent in-patient units, which are meant to accommodate about 16 children each for very short term (3 week) evaluation of children with acute mental health problems, are used to warehouse children of all kinds because the social services system has no other place to put them; young children are placed with elderly foster parents or that brothers and sisters are separated. Many children are shifted from placement to placement and from school to school; they may be placed at a younger and younger age in group homes rather than in family settings, and some are terminated from foster care and thrown out on their own at younger ages. (118)

As a result of placement shortages for abused children in New York City,

> [O]n some nights hundreds of children are left in our field offices waiting for one-night emergency beds. It is not uncommon for a child to have to wait until 2 or 3 a.m. to find some place to sleep. Caseworkers have been known to work through the night to secure beds for children. (41)
>
> At various times, NYC's social services agency has responded to the bed shortage by forcing children to sleep in the agency's office, bouncing children from one placement to another every one or two days, placing young children in excessively restrictive placements for extended periods of time, and attempting to induce psychiatric centers to take children only because they have been repeatedly placed night-to-night. (36)

Agencies and parent groups in the District of Columbia, California and New Jersey also pointed out that children often may be placed far from home, split up from siblings, and provided little or no assistance aimed at reunification.

> Children are put in inappropriate placements, not designed to offer family counseling, psychiatric treatment, or drug treatment....Children are usually placed at great distances, or even in other states....Little or no work is done to return children to their families. Most programs consider home visits to be a privilege, and visits are used as rewards for good behavior rather than as reunification tools. (68)

> We continue to see far too many foster children placed out of county, and separated from their brothers and sisters because of the lack of a sufficient number of appropriate foster homes. We see far too few visits between birth parents and/or siblings, and far too little attention given to foster parents and foster children. (27)

Witness also told the Committee that juvenile admissions to private hospital and specialized residential programs have climbed dramatically, "largely fueled by the availability of third party health care reimbursement." (102)

> ...juvenile admissions to private psychiatric hospitals jumped from 10,764 in 1980 to 48,375 in 1984. This represents an increase in admissions of more than 350%. However, these figures may be the tip of the iceberg because they only pertain to admissions to the 230 hospitals that are members of the National Association of Private Psychiatric Hospitals. (102)

> ...we are spending well over a billion dollars to serve about 26,000 children in state hospitals and out-of-state [mental health] care. And, what are we getting for our money? ...'children and families have access to either outpatient counseling or inpatient hospitalization, a situation analogous to a patient with heart disease having access to only an aspirin, or a transplant'. (141)

Witnesses told the Committee that the pertinent federal statutes "contain almost no enforceable standards of care or safety for children in state care...." (107)

> With no consistent federal standards or monitoring, many state and local systems for children don't come close to meeting basic responsibilities. (107)

According to the Office of Juvenile Justice and Delinquency Prevention, by October 1989, only 34 of 56 participating states and territories had demonstrated compliance with the requirement for the separation of juvenile and adult offenders.

For older children, many of whom may have grown up in and "graduated" out of foster care, the lack of appropriate services while in care can severely impair their prospects for functioning as independent young adults.

> Children, often after having grown up in foster care as a result of inadequate planning, are faced with being terminated from foster care with the clothes on their back and essentially nothing else. Even the most motivated 18-year-old will be hard pressed to make a successful transition to independence in the face of no place to live, no transitional financial assistance whatsoever, a minimum wage job if that, the prospect of having to quit school in order to be able to work.... (118)

> Children are not prepared to return to families, nor are they provided with a specialized educational and vocational training they need to survive after they become 18. They become the new homeless. (68)

A recent study of the experiences of youth after foster care in California demonstrated that even among those former foster care youth who might be considered the most successful, many were "struggling with ill health, poor education, severe housing, substance abuse, and criminal behavior." (153)

# CHAPTER II. CHILDREN'S SERVICES IN CRISIS

## A. State and Local Agencies, Courts Overwhelmed

### 1. Services are in short supply

In many cases, effective services are in short supply, "skim-[ming] the surface of the need." (65) Regardless of the system, the lament is the same: where services exist, they are generally ineffective, inappropriate, or inefficient.

> The range of services [is] frequently unavailable, there is very little coordination among the systems that are mandated to serve our children and there is usually no plan to determine which agencies should be responsible for serving a particular child. Consequently, our children are unserved, underserved or served inappropriately. (35)

The shortage and inappropriateness of services are common within and across care systems. Shortages of preventive services, family foster care placements, group home placements, reunification services, health care, mental health treatment, rehabilitative services, crisis and respite services, educational programs and transitional services are increasingly common. (118, 36, 69, 1, 101)

Across the country, children who are at risk of developing an emotional illness, of being abused or neglected, or of breaking the law, often remain undiagnosed or are placed on waiting lists for evaluation and treatment. (69, 65)

#### a. Most acute shortages occur in prevention and early intervention programs

Witnesses repeatedly told the Committee that needy children and families get attention and services only after the fact -- after abuse has occurred, after a crime has been committed, or after a child has died.

> The problems of these children go unnoticed or misdiagnosed through a troubled and troublesome school career

> until after repeated contacts with the juvenile justice system they are finally 'discovered.' Even then there [is] often no remediation or habilitation available. (62)

> Seven years have passed since the passage of P.L. 96-272 which mandates preventive services, and recent research has shown that services are being offered unevenly at best. There is some indication that they [services] still may be triggered more by placement than offered in preventing placement. (90)

> The flow of dollars still favors out-of-home care, at the expense of alternatives designed to preserve families or to prepare children in care who cannot return home for adoption or independent living. (1)

Services that reach and serve individuals with problems of substance abuse -- currently one of the major factors leading to out-of-home placement -- remain largely unavailable and terribly inadequate where they do exist. In the Select Committee's survey on drug-addicted infants and their mothers, two-thirds of the hospitals surveyed reported that they had no place to send pregnant women for drug treatment. (See Appendix VI) (125) A recent survey of 78 drug treatment programs in New York City revealed that

> 54% refused to treat pregnant women; 67% refused to treat pregnant women on Medicaid, and 87% had no services available to pregnant women on Medicaid addicted to crack. Less that half of those programs that did accept pregnant women (44%) provided or arranged for prenatal care; only two programs made provisions for clients' children. (18)

### b. Treatment services also remain limited

Treatment services, while more widespread than prevention and early intervention services, are also scarce.

#### (1) Child welfare/Foster care

> There are no services [in the D.C. foster care system]. As

> the Committee has heard and will hear again, it takes me years, literally years, sometimes, to get therapy for children and families....In the foster care system in D.C., there are no effective job training and placement programs. No vocational education. No assistance for kids who are coming out of foster care -- and they are getting kicked out of foster care at earlier and earlier ages, because the agencies don't want to service them. (118)

A recent report on child welfare services in the District of Columbia revealed that as of September 1989, the system had not completed investigations on a backlog of more than 700 cases involving some 1,200 children. (170)

> The Committee's [Select Committee on Children, Youth, and Families] survey[8] showed mental health services for abused children barely exist in many places. Those families whose children have been molested in day care, school or other institutional settings receive even less help. (67)

Even where they exist, placements and services are all too often inappropriate or ineffective. They are still often provided away from home or outside the community which is familiar to the child and the family or are mismatched with families' needs for other reasons.

> Treatment programs are not well developed or widely available, especially in the outlying portions of our service area. Due to reductions in 3rd party payments for mental health therapy, abuse victims who require long-term care are prevented from receiving these services as sources with sliding fee scales have long client waiting lists (including examples in TX, WA, CA, AZ). (108)

In a series of hearings on Native American children and families, the Select Committee learned that Native American children who receive services separately under the Indian Child

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[8] Select Committee's 1986 survey on child abuse and child welfare. See reference no. 124.

Welfare Act fare poorly too because of inadequate services and resources. (87)

> Child protection, substitute care, pre-adoption and aftercare services are offered by all tribal programs, but the range of services is limited. Referrals to other social services are the norm. Availability of these services from tribal programs depends upon other resources the tribe has been able to marshall....The high caseloads carried by many tribal child welfare workers hamper efforts to deliver needed services to clients. Among the current and projected needs of tribal programs are family-based services, mental health and substance abuse counseling and treatment services, day care, youth/adolescent homes and services, and emergency shelters. More staff, training and technical assistance in preventive and protective services, and procedural manuals would be beneficial. (147)
>
> The state sometimes retains custody of Indian children improperly simply because the tribes do not have the resources to meet their obligations under the ICWA." (87)

### (2) Mental health

Mental health services also seldom get to children in need.

Even when figuring that only one to two percent of children may require services at any point in the public sector-- "a figure considerably lower than overall prevalence -- indications are that our public systems are falling considerably short of effectively reaching even these children who are most in need." (40)

> ....[A]lthough severe behavior disorders in childhood are serious disorders of mental health, responsibility for preventing and treating such conditions is widely diffused. A patchwork of child treatment services (and financing for them) has developed in an unplanned fashion. (81)

An estimated 70% to 80% of emotionally disturbed children receive inappropriate mental health services or no services at all.

(133) Shortages exist in all forms of child mental health care. Witnesses highlighted the scarcity of community-based care, case management, and coordination across educational, judicial and other child serving agencies. (1, 79, 40, 81, 104, 133) Community-based mental health clinics are so overwhelmed by the demand for services that only the most disturbed children get help.

> Our outpatient clinics have a waiting list typically of 50 children. We are triaging. We are only seeing those children that are...violently hostile or imminently suicidal. (79)

In addition, on any given day in high-growth, suburban Contra Costa County, California, "at least one mentally ill child is consigned to an adult inpatient psychiatric ward because no appropriate placement is available." (79) In Erie County, New York, as of July 1987, some 600 children were on a waiting list for outpatient mental health services. (104) Nationwide, there was a 14.3% shortage of special education teachers for emotionally disturbed children during the 1985-86 school year. (167)

In short there seems to be no type of children's mental health service that is in adequate supply.

### (3) Juvenile justice

The juvenile justice system reflects a similar scarcity of services and treatment, whether community-based or not.

> The problem is further complicated by the inadequacy of existing services for emotionally disturbed, the violent, aggressive, sexually abused, or mentally retarded child, who is adjudicated, and by the lack of funds to develop these services. (5)

> Over the past few years community-based services essential to court services have been dwindling. Most notably, we are referring to the additional need of indigent offenders in our courts and also we're talking about mental health services have been declining. (2)

> [In 1985, a class action suit, filed against the District of Columbia on behalf of all the children incarcerated in the City's juvenile detention facilities], charged that the facilities lack appropriate education services, special education, vocational training services, medical, psychological and psychiatric services, as well as sufficient staffing patterns, staff qualifications and training. In July 1986, the defendants agreed to a settlement of all issues which will achieve the goals set forth by the suit....The real tragedy is that such a law suit was needed. (106)

Ironically, some witnesses suggested that the juvenile justice system is often used inappropriately because no other services are available. (39)

> The juvenile justice system becomes the social service agency of first resort. The only way a lot of these kids can be assured of getting halfway adequate social services is by getting locked up....I've seen concerned police or probation officers incarcerate a kid just to see to it that kid gets a couple of nutritious meals every day, gets some basic medical services, and has someone to keep them from hurting themselves or damaging their brains with chemicals, at least for the time being. But of course, without some deeper intervention the underlying problems those kids bring to the system are left unresolved. The result is that the juvenile justice system just becomes a kind of revolving door. (25)

> There are still neglected and abused children in jail because there is no other place. (39)

In sum, whichever systems needy children encounter, the services they receive are likely to be insufficient and/or unresponsive to their needs.[9]

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[9] To redress these and other deficiencies, legal action has been brought on behalf of children in state care in more than 20 states over the last decade. See Appendix V for a listing of cases.

### 2. Foster families are fewer in number and inadequately paid

The foster care system has traditionally relied on families and service agencies in a community to provide homes for children whose biological families cannot care for them. As a foster parent for more than two dozen years told the Select Committee, the ingredients of a strong foster family home system are known.

> ....It means recruiting and retaining foster parents who can provide quality care to the children placed in their homes until these children can be reunited with their birth parent(s) or be adopted. It means having appropriate support services in place for both foster parents and foster children to prevent placement disruptions. It means having a sufficient number of agency staff to work with all children and families under supervision. (27)

Yet, the reality of today's foster care system falls short of this ideal in almost every way. The number of available foster parents is inadequate and shrinking. This reflects the fact that the pool of families potentially available to be foster families has been reduced because of the changing demographic profile of American families in which both parents work. Consequently, there are fewer families available to assume the responsibility of being foster or adoptive parents. (77, 60, 27, 92, 99, 73) Yet, agencies have not always recognized the need to adapt to the new demographic realities.

> Regulations say we need many more foster and adoptive parents. Practice says screen out singles, low or fixed income people, people over a certain age, women who work and on and on. Simply put, regulations and practices are not mirrored images. (92)

In addition, there has been insufficient assistance to foster parents to enable them to support and properly care for these children, many of whom have special needs.

Foster care reimbursement levels remain so low that the economic realities of caring for a child dissuade otherwise potentially interested individuals from even considering becoming a foster parent.

> The traditional foster care model, I think frankly, is romanticized public-spirited volunteers paid a fraction of the costs of rearing a child, providing home-based care for abandoned children....The pool of foster homes is alarmingly low, especially in urban settings. The reimbursement rates for foster care are too low to make such care economically feasible for many families. (99)

> Being a foster parent is not an easy job. It is difficult to find people who are willing to be foster parents. You don't become a foster parent to get rich. Foster parents are always paying for things with their own money because the money we receive for caring for children is never enough to cover the things they need and want. The amount of money we receive per child is approximately $10 per day. (45)

> Many foster parents have had their homes and property damaged, and even had fires set by foster children. We receive no liability insurance from the Department of Human Services. Foster parents receive no social security benefits. (45)

The demands placed upon foster parents are more difficult than they used to be. Since children entering state care have increasingly severe and complex problems, they need foster parents and adoptive parents who have the specialized knowledge, capacity, supports and fiscal resources to meet those needs. (1)

Calling the shortage of foster parents "critical," the GAO recently found that "increasing numbers of foster parents are ceasing to provide care because they do not receive support and positive recognition in dealing with difficulties they face in caring for today's foster children." (146)

Dealing with the foster care and child welfare systems presents additional barriers that can discourage foster parenting.

Witnesses report that, while agencies have set new directives emphasizing permanency planning, they have failed to help foster parents adjust to this reorientation of policy.

> The purpose and role of foster care has consequently shifted to a temporary service with emphasis not only on protection, but also permanency for the child. However, no consistent effort has been made to either inform foster parents or to define for them the implication of this new purpose and role....Now, the (foster) child and his or her (natural) family are identified as the 'clients'...the result for foster parents has been a drastic reduction in the availability of direct service staff as a source of support. Consequently, foster parents frequently feel isolated and without essential support. (60)

Further, foster parents report persistent problems of grossly low and often late reimbursements, inadequate or no medical care for children in care, poor communication with workers, and exclusion from decision making regarding the child(ren) in care. (114) In addition, witnesses identified a lack of emergency services, respite care and baby-sitting services for foster parents. (45) As a result, foster parents are increasingly isolated and left to fend for themselves and the children they care for.

In the face of these difficult conditions, many jurisdictions continue to lose foster parents.

> A large number of foster families leaving the system was apparent. For example, in June 30, 1984, we had about 3,500 foster homes and in June 30, 1986, we had approximately 2,800 foster homes. (60)

As a result, states and localities are renewing their foster parent recruitment efforts. While requiring more aggressive outreach and more creative strategies, specially targeted recruitment has shown positive results.

> We have talked today about the difficulty of finding enough foster and adoptive homes for the more difficult to place children. However, the majority of agencies do little or no

> recruiting for foster families. Those who do launch recruitment efforts are generally inundated with inquiries, but are unable to respond to them effectively. (92)

The recent GAO assessment calls for a comprehensive evaluation by DHHS of various foster parent recruiting strategies to identify and support effective practices. (146)

### 3. Adoptive homes are limited

Securing adoptive homes for today's foster children is made more challenging by the needs of these children.

In 1985, adoption was the goal for approximately 36,000 of the 276,300 children in foster care nationwide. Of the more than 16,000 children who were awaiting adoption that year, 71% were older than six years of age, 47% were minority, 51% were classified as "special needs," and 79% had been waiting longer than six months. (161)

Witnesses report multiple problems and delays in placing children for adoption.

> Studies are indicating that even when adoption or reunification has been identified as a goal for a child, it takes years to implement. And the time in a life of a child is much different than time in the life of an adult. [e.g., in Maryland it takes 5 years for a child to be adopted, in Baltimore County it takes 7 years] (92)

> According to the Foster Care Monitoring Committee's report to the Mayor of New York in September of 1984, children wait an average of 6 years in foster care before being adopted even though the Child Welfare Reform Act of New York prescribes a maximum period of 48 months from time of entry into foster care to an adoptive placement....Our experience tells us that the recruitment of families, including minority families is not the problem. Culturally and racially sensitive recruitment programs have proved successful in many areas of the nation. The major problem is getting these families through the system.

> Although we prepare our families to anticipate delays, about 25% drop out after referral to an adoption agency for the homestudy process [which takes between 6 to 9 months, instead of weeks as it should]. (74)

> One unfortunate side effect of our intense focus on developing new foster care options, and our efforts to cope with the rising numbers in protective services, is that our efforts to locate permanent homes for children available for adoption have suffered....[B]y the end of February we had found adoptive homes for only 650 children, and it looks to me as if we'll fall short of our goal of 1,200 placements by the end of this fiscal year on June 30. (48)

### 4. Legal protections are constrained

The legal system and the courts, like every other system trying to meet the needs of these children, are overwhelmed by numbers and conditions.

> Courts do not have the time or are not taking the time to make the inquiries and findings required by P.L. 96-272. (61)

As a result, according to judges and legal advocates, children and parents often do not get the kind of representation they need. The effectiveness of the court process depends on the knowledge and skill of the judge and lawyers for all parties; in some places, children don't even have lawyers; for the most part, they are poorly paid, poorly trained, and are often involved because they need the income to make ends meet or to gain courtroom experience. (54, 61)

> Parents do not experience due process which includes a speedy trial. During the time gap, they are denied custody of their children....Children have very few opportunities to verbalize their feelings at court. [And] children do not understand continuances. (31)

> While the Child Abuse and Treatment Act of 1974 mandated that children in abuse and neglect cases have a

GAL (Guardian Ad Litem), it was not mandated that GAL's be attorneys; there are no substitutes for skilled lawyers in court proceedings. (61)

Parents are even less likely than children to be represented by skilled legal advocates. (61)

The Committee also heard many times about judicial system failures due to high turnover among juvenile and family court judges and among court staff. (61, 103)

Witnesses offered a range of suggestions about how services for troubled children and children in placement could be improved.

Numerous witnesses strongly urged the establishment of expanded and additional services and strengthening those provisions of law that are designed to insure services are provided. The following were suggested:

- development of a continuum of services to meet the needs of vulnerable children. (15, 40, 82)
- expanded support for more community-based and family-based services programs in prevention and treatment efforts. (71, 55, 117, 54, 30, 91, 1, 115, 121, 4, 116)
- increased preventive and reunification services (including day care, respite care, emergency housing, emergency financial assistance, transportation expenses for visiting and attending required programs) that will be provided on a consistent, statewide basis. (117, 54, 61, 115, 27, 121, 91, 4, 36)
- additional housing and shelter programs for homeless youth and youth leaving a system of state care. (121, 116, 84)
- improved educational services, including the identification of these students, trained personnel who can trace and find records lost in the numerous moves of the students; counseling to facilitate ongoing school adjustment; tutorial

services to bolster skills and learning self-esteem, the creation of agency scholarship programs to provide financial assistance to student clients beyond high school. (21, 27, 1)

- improved provision of health services by amending the case plan and case review requirements of P.L. 96-272 to require that they include specific information on the health and education status of children; requiring states to ensure that children receive health screenings and comprehensive medical assessments and treatment, including dental services in a timely manner, and that a medical passport accompany each child throughout his stay in the foster care system, upon his return home, adoption or emancipation. (1)

- sponsorship of a special initiative by Congress to help multi-problem children in foster care; e.g., medically fragile and drug dependent infants, children with serious mental health problems, and other hard-to-place children. (86)

- increased service support (e.g. respite care, counseling, insurance), training related to standards, and funding to recruit, train and compensate potential foster and adoptive parents. (71, 27, 55, 110, 119, 78, 66, 91, 28, 45) David Liederman, Executive Director of the Child Welfare League of America, and others (1, 13, 119) suggested that the training of foster parents and staff of child care institutions should be recognized as a Title IV-E training costs, similar to the Title IV-E training provision for state agency personnel, and that the state should pay for the transportation and child care costs to encourage foster parent participation in such training.

Mark Hardin, Esq., who testified on behalf of the American Bar Association and Anita Weinberg, Esq., an Assistant Public Guardian in Cook County, Illinois, suggested that P.L. 96-272 could be strengthened to include greater procedural protections to children in the foster care/child welfare system. They urged amending the law to require that the child, through his attorney, be given a copy of the social worker's plan; that attorneys be notified of administrative review hearings and that they be permitted to attend the hearing; that a pre-removal administrative hearing be held prior to the child's removal from one placement; and that the law specifically provide the child with a private cause of action. (54, 117)

In the mental health system, specifically, several witnesses felt that what is probably most important in the mental health area is to establish the principle that children have a right to mental health treatment. (101, 65)

Judge Jones, of Charlotte, North Carolina, went further urging "extending the mandate of P.L. 96-272 to delinquent youth, status offender and mentally ill children." (61)

## B. Services Limited by Staffing Problems

Many children and families do not receive the help they require because workers and supervisors lack adequate training, supports or resources. (1)

Increasingly large caseloads that children's services staffs have had to carry constitute one of the major problems. The recommended standard caseload size for family foster homes is 20-30 children per children's services worker. (154) No representative of any children's services system that has come before the Committee during the last several years has reported a caseload size nearly as low as that goal, and that standard was developed more than a decade ago when the problems were much less difficult and much less complex.

> In my own unit in south central Los Angeles...the average caseload is between 75 and 78 and rapidly climbing....The demands of caseloads this size are overwhelming....Face to face contacts or mandated activities in regards to monthly visitations are another demand....CSWs [children's social workers] do not have time to do the state exemption forms which would require them to do less phone calls. They do not have the time to make all the home calls they are supposed to make. Monthly visitation statistics which come at the end of the month and which our Department relies on, are inaccurate and inflated. Workers are forced to lie, to find the happy medium between mandated activities and

> the avoidance of administrative pressures. We are Band-[aid] crusaders running from one fire to another and sometimes we need Band[aids] ourselves. In March, last month, we lost 40 CSW's. Our average attrition rate is 15 or 16. (98)

Witnesses representing every service system provided similar evidence documenting serious staffing problems. There are too few workers, excessively high caseloads, inadequate basic knowledge and training, high burnout and turnover, and frequently dangerous working conditions. (85, 113, 103)

> Currently, social workers have caseloads which often range as high as 60-70 cases. There have even been reports of workers with caseloads of 120. Common sense tells us that the social workers cannot properly provide preventative and reunification services with caseloads of that size. It is mathematically impossible for them to even visit the children let alone as frequently as is necessary to provide the proper social work services needed by these children in order to allow them to remain with or be reunited with their families. (85)

> In our probation department, juvenile probation officers are carrying caseloads of between 65 and 80, typically in the range of 30 children a day. There is no way on earth they can adequately serve that number of kids. (79)

And in the court system, according to Judge Jones from North Carolina, "[d]ozens and dozens, perhaps as many as one hundred cases may be heard by a single judge in one day." (61)

As the problems facing vulnerable children and families have grown more complex and severe, knowledgeable and well trained staff have become even more essential. Staff need to understand the factors affecting today's children and their families, such as poverty, homelessness, drug abuse, and family violence. They need to know where to go to find appropriate services. Most importantly, they must have the training to make daily judgments about children's safety and well-being. (79, 67)

Yet, workers in every children's service system often lack these skills. Child welfare workers are frequently unprepared for the tasks they face:

> Child protective services...is dramatically different now and not just because the system seems to be overwhelmed by huge numbers of cases, but also as a secondary by-product of that being overwhelmed, the character of who the workers are and what their training is has also changed. In our view, we have seen fewer and fewer individuals who are actually trained in social work involved in child protective services. I heard the figure from some of my colleagues that it is now only 25% of child protective services workers who are trained in social work....And the turnover rate, because the work is so difficult, is so high that while recruitment doesn't seem to be a problem in that field, retention is certainly a major issue. (67)

> We have very, very few individuals in practice in child protection whether they're in medicine, social work, law enforcement or attorneys, or judges, for that matter, who have had any concrete curriculum that has to do with that particular field. Abuse and neglect is not just a medical or social or a legal problem, it's a child's problem and a family problem. And, as such, it relies on all of those professions, medicine, law, social work, law enforcement, district attorneys, judges, mental health and schools that work together to make it go. And that system will only be as strong as its weakest link. (67)

> ...not only are we working with primitive tools, but the people whom we know to be the best qualified to serve these kids and their families are often walking away from the practice of child protective services because the working conditions are far too difficult. (77)

Similarly, staff in juvenile justice and mental health fields, are not equipped to handle the problems of the children and families coming to them.

> There really are not very many mental health people

> trained specifically in child and adolescent services, and when they are trained, very often their training is traditional and trains them to do either outpatient or inpatient therapy rather than the more complex kinds of treatment that we are talking about. (65)

> I think part of the problem is that traditional mental health services, which really do mean sitting and talking to a child or a parent, et cetera, simply do not work for this large population of kids, and the mental health professions themselves, both psychologists and psychiatrists, have really not rushed to do all the other kinds of things that are necessary to provide appropriate treatment to these kids. (65)

Although there is consensus that training and retraining needs are substantial, few appropriate curricula and resources for training are available.

> There is a major gap between what the public sector needs in terms of the type of training for social workers, counselors, teachers, psychologists, psychiatrists, and the type of training that tends to be provided in the universities. The type of training is much more geared toward people who will be working for more third-party payments or outpatient and hospital kinds of services. (40)

> Over the last five years, virtually all money for people who were going to do clinical work has dried up. There are no longer NIMH training funds, certainly not on the order that there were 10 and 15 years ago, and that from a university perspective, is inhibiting our ability to train people. (101)

Thus, at the very time the system is most challenged by the needs of families and children, the capacity of the workforce to meet those children's needs seems to be eroding.

Administrators and advocates alike urged increased funding for the training of personnel in the agencies which provide care. Suggestions included mandating that states provide in-service and on-going training to staff, and making such training a condition of continued employment; establishing national education, training and certification standards for Child Protective Services workers; and establishing specialized support units to assist caseworkers with cases demanding special expertise in areas such as substance abuse, sexual abuse, emotional disturbances, developmental disabilities, special education, and/or independent living. (1, 44, 110, 13)

## C. Current Services are Uncoordinated and Fragmented

Even when services exist, they are not organized or designed in a fashion which responds comprehensively to the needs of the child or the family.

> [In Unclaimed Children,] we tried to find out what States were doing in an interagency way; and what we found out, virtually nothing. This was particularly shocking since we know that many of these children are really exchangeable children. Whether they end up in juvenile justice or child welfare or mental health is as much a matter of chance as it is any differences in assistance or in the kids. (65)

Administrators and practitioners concur that almost nothing has been done "to make structural linkages between education, health, mental health, developmental disabilities, juvenile justice, and legal systems." (78) In fact, structure, "turf" issues and categorical program design were cited repeatedly as principal barriers to delivering needed services to troubled children and families.

> There must be better coordination of services between systems; kids fall through the cracks as they pass from system to system; we don't have uniform policies, definitions. (23)

> As a result of [the] specialization of services and training, each program or agency tends to view the client in terms of the services or training provided by that agency and to ignore other problems that are contributing to the behavior that has the youth involved with the agency to begin with. By that I mean we are going to look at them in terms of

> the services that we are able to provide ourselves. A school looks at a kid in terms of academics, period. That is all they are going to look at them in terms of. They are not going to look at them in terms of the home or what is going on. This is an example of the need for individualized, coordinated, comprehensive services. What we have ended up with is fragmented services, and we have taken the approach of working with people that is bits and pieces. (30)

> The major obstacle to serving these multiple problem children is that we only have single problem funding and service delivery systems (child welfare/foster care; mental health; juvenile justice; special education). For California historically there has been very little joint planning, interagency case management or blended funding. I believe that the primary reason for resistance to a comprehensive approach is the concern on the part of professionals both in and out of government that such an approach will threaten existing categorical funding streams, will reduce the influence of the specific professional specialty and will threaten the single service 'turf'. Any public policy initiative must take this reality into consideration. (15)

> Because of fragmentation and duplication in the delivery system, services never reach their target population and children fall through the cracks because of unnecessary procedures or restrictive eligibility requirements. (4)

One harmful outcome of this uncoordinated way of organizing services is that children are given stigmatizing labels which also often limit the services they can receive.

> Children in one system are often ineligible for services from another. Labels are attached to children who enter public systems -- some are 'abused,' 'neglected,' 'dependent' or 'emotionally disturbed'; others are 'runaways' or adjudicated youths' -- but the labels tell nothing about the children's special service needs. Rather, they only indicate to which public agency responsibility for a child has fallen and the restrictions that will apply to the child's care. (1)

> This fragmentation is everywhere. Some children are labeled dependent or neglected and are placed under the jurisdiction of the Department of Social Services, other children are labeled delinquent and are under the Juvenile Court or Probation Department, still others are given psychiatric label and sent to the Department of Mental Health. Indeed, the same child may get different labels at different times....In reality, all of these children may have serious emotional problems, and all certainly come from families or other living situations marked by acute crises. This labeling approach creates barriers to the delivery of services. Department of Social Services resources, such as foster care and group homes, are not readily available to delinquent children. Intensive psychiatric services are not provided to neglected children who need them... In the worst cases, agencies ignore the needs of the most unwanted children, or dump them in the laps of other agencies. For example, it is common for mental health agencies to refuse to accept delinquent children who have histories of aggressive behavior, no matter how compelling the children's mental health needs, so that children are warehoused in large correctional institutions. (107)

To address the many ramifications of the system's fragmentation, one witness underscored that:

> System boundaries must be permeable; mandates and requirements must be developed that protect children, not bureaucracies; financing must be available at levels to support needed services; and professionals must not specialize such that children are left in no-man's-zones unable to be assisted by the collective public agencies. (104)

Given the current unevenness and inadequacy of services to children, the clear recognized need for integrated service delivery, and the equally clear resource limitations, witnesses suggested to the Select Committee ways to facilitate cooperation and coordination among service agencies and systems:

- establish state interagency councils to facilitate dialogue among the various public agency systems. Witnesses suggested that this could be accomplished by Governors or by federal mandate to assure that such councils have the necessary authority to ensure joint funding and other cooperation among agencies. (78)

- provide higher federal matching funds for states that train administrators and workers from different systems and agencies together. In order to be eligible for this higher matching rate, states would be required to describe the sequence of training activities, the nature of the training, and their plans for having staff from various agencies deliver such services. (1)

- encourage states to establish a "children's services system," whereby one system would assess, plan for and serve children and families in need. Such a system would coordinate existing services and programs to assure that the needs of children and their families are met. (96, 55, 27, 1, 4)

According to one witness, such a system would have:

> One central intake point where each child and his family would receive a full developmental assessment that identifies his/their needs and identifies a comprehensive set of services to meet these needs. The family would be actively involved in the delivery of services and the services would be delivered in the child's home and community whenever possible. (1)

## D. Financing Mechanisms and Funding Inadequate and Misdirected

### 1. Resources and fiscal strategies are seriously lacking

About a dozen federal programs help states pay the costs of preventing out-of-home care or supporting children who require such placement. (These programs and recent funding history are described in greater detail in Appendix IV.)

By far the largest of these programs is the federal foster care program (Title IV-E of the Social Security Act) which assists states in paying costs for AFDC-eligible children who are in foster care. In addition, the child welfare services program (Title IV-B of the Social Security Act) supports state services that try to avert or address family crises. The Social Services Block Grant (SSBG, Title XX of the Social Security Act) also provides funding to states for activities determined appropriate social services by the state, including protective services. However, because of the block grant funding, the amount of Title XX funds allocated to child welfare services cannot be specified.

In the area of juvenile justice, the Juvenile Justice and Delinquency Prevention Act of 1974 funds state and local programs that seek to prevent, treat or otherwise address delinquency.

Federal support for mental health services comes from a variety of sources: the Alcohol, Drug Abuse and Mental Health Block Grant provides the largest funding resource for prevention, treatment and research programs, though few of its resources are directed specifically at children. Trends in program funding and children served are shown on Table 11.

For most of these programs, resources available over the last several years have failed to keep pace with the escalating caseload of troubled children and their families. In particular, resources have not been dedicated to prevent crises or to intervene earlier before problems escalate. The available resources are absorbed largely by the most pressing crises. (90)

> Growing caseloads and increasing expenditures have resulted in reduced efforts at preventing placements and providing effective alternatives to foster care. (1)
>
> Resources for prevention are limited: some states have directed their efforts to crisis intervention exclusively; reduction in range and frequency of services provided has left too many children at risk. (1)

All systems providing out-of-home placement have been swamped by the substantial growth in the number of children entering and re-entering care and the increasingly difficult problems that accompany them. As the demands that have often led to out-of-home care have soared, the one area of spending that has seen growth is spending to maintain children out of home.

For example, federal costs for the Title IV-E program which supports children in foster care have grown rapidly. While the number of IV-E eligible children[10] increased about 14% from 108,104 in 1985 to 122,949 in 1988, federal payments to states in total absolute dollars for the care of these children grew from $546 million in 1985 to $891 million in 1988. Assessment of the real growth of federal payments in constant 1981 dollars shows that federal funding for this program grew 46% from 1985-1988.[11] (See Chart 4 and Tables 11 and 12)

This expenditure growth reflects several factors. The increased costs in this category reflect improved cost-claiming practices by states allowable under the 1980 law. In addition, as states have recognized the need to respond to increasing crises, they have greatly expanded claims under the Title IV-E "administrative costs" category of reimbursement, which includes the costs of case management and other permanency planning activities for children. (See Table 13)

Whether these higher expenditures have resulted in significantly more appropriate and more effective services to children and families remains unanswered because of inadequate oversight and the lack of basic and evaluative data. To date, Title IV-E

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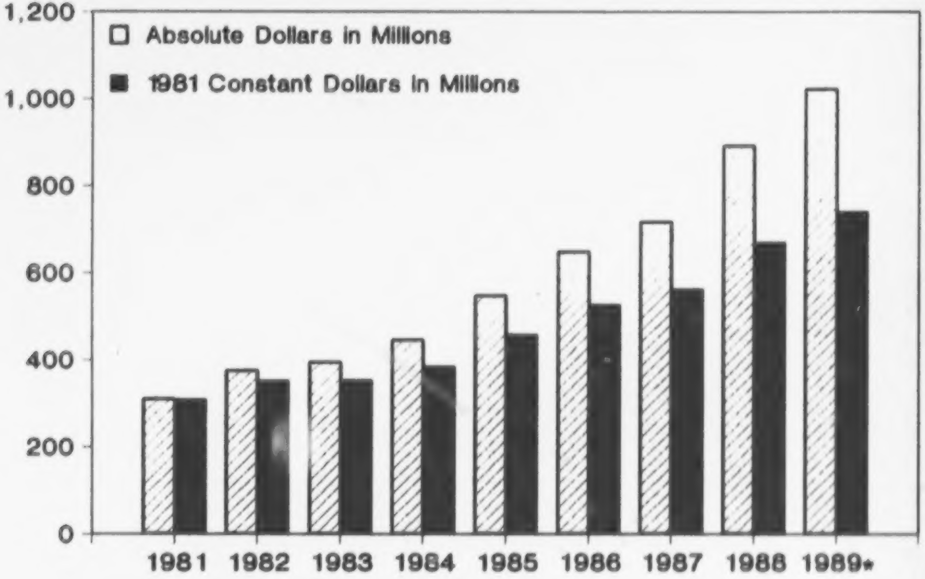
[10] Eligible children under Title IV-E of the Social Security Act are those children whose family income make them eligible for public assistance under the Aid to Families with Dependent Children program.

[11] Constant dollar adjustments calculations based on 1990 Budget Implicit Price Deflators for Composition of Total Outlays, OMB, January 1989. Title IV-E constant dollar estimates should be viewed with caution as program funding may be claimed for up to 2 years after service year.

Chart 4

## IV–E Foster Care Program Funding

### 1981 – 1988 and Projected 1989



Source: See notes Tables 11 and 12 in Appendix I.
*Projection.

funding and administrative practice have not distinguished sufficiently between direct services and administrative costs, thus it is difficult to determine how the funds have been utilized. As crisis situations have increased and gained greater attention, however, these expenditures have become increasingly questioned.

Experts concur that there never has been sufficient federal funding to "investigate reports as defined by the CPS and provide the necessary related services." (114) Child welfare services, for example, under Title IV-B have never been fully funded; Title IV-E funds placement only for children receiving AFDC (only about 40% of those in foster care); federal grant funding for child abuse prevention and treatment remains low; and the "gap has widened between problems that must be addressed and resources available." (77) And, in contrast to higher placement costs, other services have suffered real drops.

The funding history of the child welfare services program, which was designed to ameliorate family crises provides an example of the slow growth of services that support families in their community. The program was authorized in 1980 at a funding level of $266 million. Despite dramatic growth in the numbers of children and families in need of these services during the last few years, funding for this program began at $163.5 million in 1981 and grew only to $246.7 in 1989, less that a 10% real increase in constant 1981 dollars. (See Tables 11 and 12) Furthermore, funding available for this program still has not reached the originally authorized level. (See Chart 5)

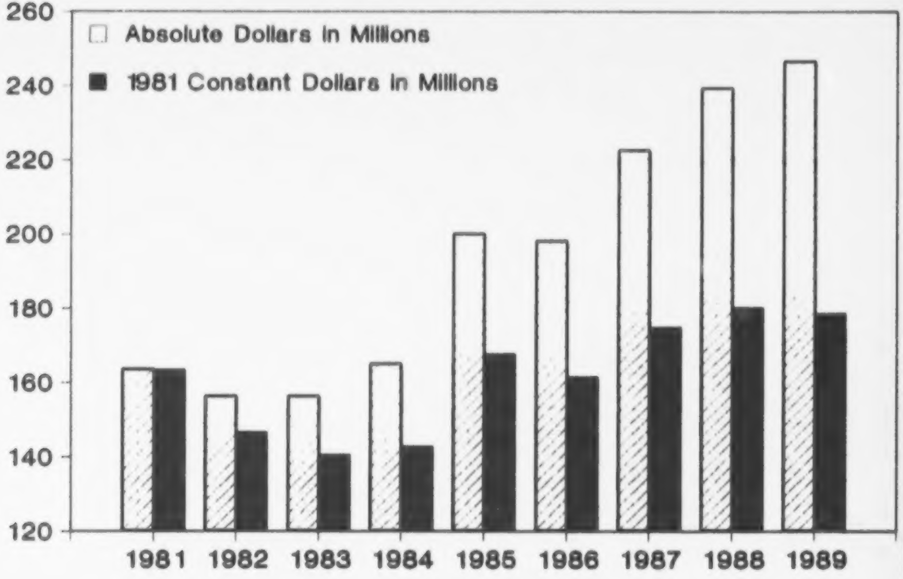
> There is a serious lack of funding, both state and federal, to adequately provide the necessary range of family support services envisioned by the law, including pre-placement and reunification services. (4)

Other funding sources have grown even less. Funding for the prevention and treatment of child abuse -- one of the leading causes of out-of-home placement -- also has not kept pace with needs. The Select Committee's 1987 survey on child abuse and

Chart 5

## IV-B Child Welfare Service Program Funding

### 1981 - 1989



Source: See notes Tables 11 and 12 in Appendix I.

child welfare services documented nearly a 55% increase in reported abuse and neglect cases while there was only a 2% increase in real funding to address the problems. (124) Current assessment shows continued decline in real resources to address the problem. In 1981, funding under the Child Abuse Prevention and Treatment Act of 1974, as amended, stood at $22.9 million; in 1989, at $25.3 million. In constant 1981 dollars, funding for the prevention and treatment of child abuse had dropped 20% by 1989. (See Table 12) Yet, an estimated 2.2 million reports of child maltreatment were made in 1988, up 82% over the number of reports in 1981. (122)

Similar issues regarding funding levels and strategies can be raised in the area of juvenile justice, with more youth entering costly detention and fewer resources aimed at earlier intervention. The U.S. Department of Justice reports that the total annual costs for state and local governments operating public juvenile facilities reached nearly $1.46 billion -- up 32% between 1982 and 1986. Nationally, the annual per resident cost averaged $27,000 in 1986. (States' average costs ranged from a low of $16,500 to over $78,000.) While cost data for private facilities are not yet available, the costs are known to be very high, given the rapid increase in numbers of youth in private facilities and in the number of the facilities themselves. (129, 132)

Even though more state and local resources are being spent on youth in facilities, the demands on this system have outpaced the resources and as a result, widespread overcrowding of facilities is common.

> I also had the support of the Superintendent [of Montrose Training School in Maryland] who was extremely cooperative. He readily admitted the institution was in need of help. Although he had asked for funds to improve the conditions, his pleas were ignored. When I arrived at Montrose, evidence of neglect [was] everywhere. Overcrowded, understaffed, badly in need of repair; it seemed to me that virtually everyone had given up. Best description I can give is it was a human warehouse. (53)

The federal contribution to address the problems of troubled youth have declined sharply. For example, the Juvenile Justice and Delinquency Prevention Act was designed to develop and support programs aimed at the prevention and treatment of delinquency among youth. Yet despite the growth in the number of juveniles in public facilities during the 1980s, appropriations for this key prevention effort have been dramatically reduced. In 1981, this program was funded at $109.2 million; by the mid-80s, funding had been reduced to under $70 million in 1989, declining more than 55% in real terms. (See Chart 6 and Tables 11 and 12)

In the mental health system, limited funding for children's services is also a significant problem.

> The needed resources are not there....Part of the problem is clearly the way the funding is used. But I don't want to diminish the fact that part of the problem is that there is just an absence of adequate resources also, and I really, particularly over the last couple of years, have not seen indications of large amounts of new funds that are coming for the kind of services we are talking about. (40)

> I think it is important to distinguish between general mental health budgets and targeted monies for children....For example, the only targeted monies for children through Federal dollars are ÇASSP monies, and some States have used the set-aside from the block grant, but basically most of the block grant money goes for the adult chronically ill. (65)

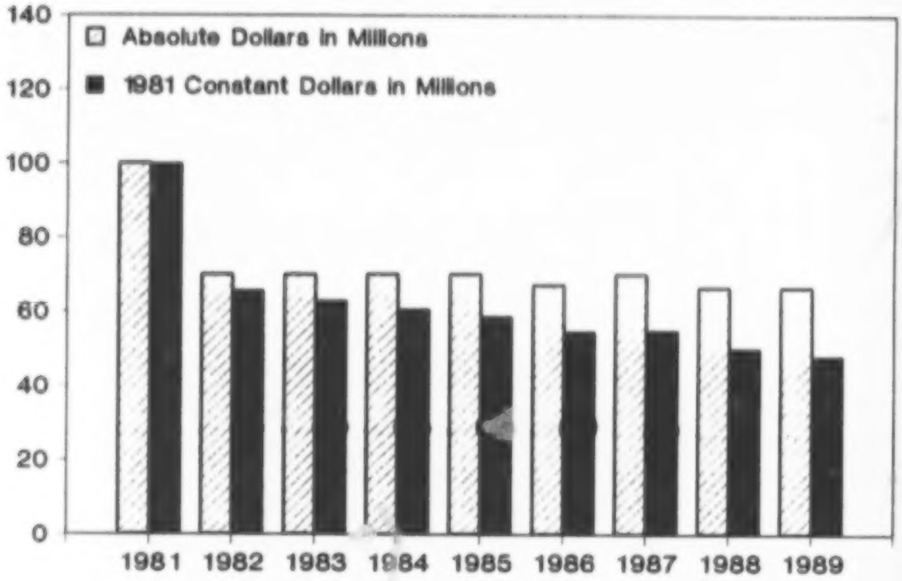
> There is some evidence...of community mental health centers cutting back on children's services, which tend to be more costly because you need more specialized people.... There is some evidence that the easiest thing to do is to reduce children's outpatient mental health services, for example, which have never been very extensive to begin with. There are many community mental health centers in this country that have no children's specialists at all. (65)

While the costs of care for children in the mental health

Chart 6

## Juvenile Justice Program Funding

### 1981 - 1989



Source: See notes Tables 11 and 12 in Appendix I.

system are particularly difficult to estimate because of the variety of service providers and payment mechanisms involved, it is apparent that children's needs outstrip available resources. Witnesses told the Committee about the high costs of care for children in the mental health system.

> California's current financial liability for its 10,000 identified target population children exceeds $240 million annually in residential and State hospital costs alone, and these children's experience puts them at the highest risk of remaining public charges for their entire lives. (34)

In the 1980s, funding for federal alcohol, drug abuse, and mental health programs also dropped precipitously. In 1981, funding for the combined categorical programs was $519 million compared with $428 million in the first year of the Block Grant program. Although funding for the Block Grant increased to $502.7 million in 1989, this reflects a decline in real terms of 30% since 1981. (See Tables 11 and 12) Furthermore, only 10% of the mental health share of the Block Grant is set aside for community-based mental health services for seriously emotionally disturbed children and youth, and this set-aside has only been mandated since 1988. (See Chart 7)

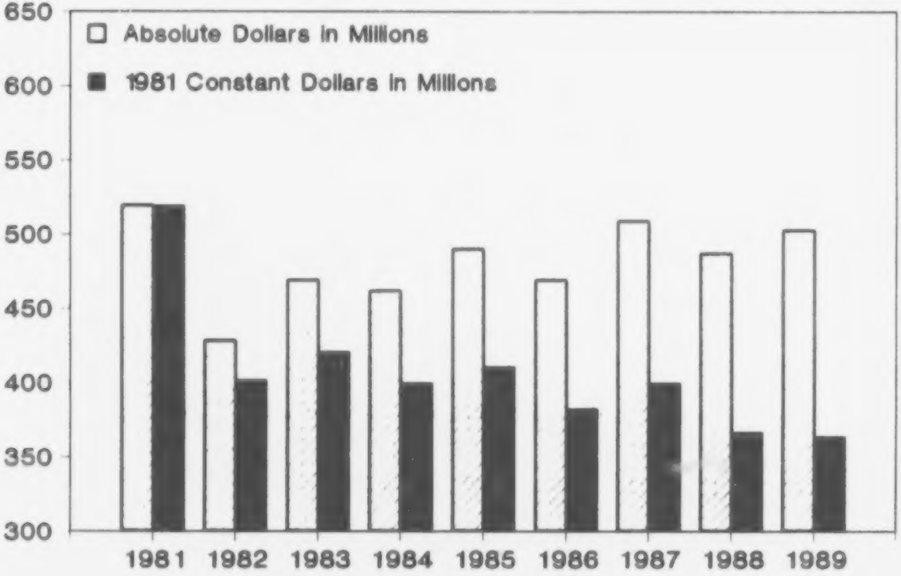
In addition to these major programs, the Social Services Block Grant which funds a variety of intervention and support services for vulnerable children and families, has not received any increase in funding over the last several years, remaining at $2.7 billion -- effectively a real drop in funding -- despite growing needs in every state. Because this program is a block grant to the states and reporting requirements were effectively eliminated in 1981, it has been virtually impossible to determine precisely what resources states apply to child welfare services. (Table 11) (See also Appendix IV)

In sum, with very few exceptions, such as Title IV-E foster care payments -- principally dedicated to maintenance of children in out-of home care -- federal support for vulnerable children in the child welfare, juvenile justice, and mental health systems has grown slowly or has been reduced, while children's and family needs have increased in number, scope and complexity.

Chart 7

## Alcohol, Drug Abuse and Mental Health Program Funding

### 1981 - 1989



Source: See notes Tables 11 and 12 in Appendix I.

The shortage of resources promotes a constant shuttling of children across the various agencies serving children, as each agency attempts to reduce its caseload and take advantage of the reimbursement systems available.

> Because of the shortage of resources, social services agencies fight to avoid being saddled with the responsibility of providing services to children. Older children are not brought into the neglect system because they will be hard to place. The neglect system tries to dump children in the juvenile and mental retardation systems, which have no resources either. The neglect system will tell you that the mental health system is responsible for providing all mental health-related services (therapy, therapeutic foster homes and group homes, etc.) while the mental health system says that the neglect system is responsible for caring for its own wards. (118)

Funding shortages are not the only problem. Categorical funding has impeded drawing together the array of services which children may need regardless of the system through which they enter.

> The bulk of state's money in key areas is inflexibly tied to out-of-home care; artificial labels and arguments about who's in charge and who pays determine service delivery to an unfortunate degree. (4)

In addition, current financing mechanisms direct dollars away from the preventive services which have the potential to avert later and more costly problems. In fact, witnesses suggested that current funding policies create incentives toward maintaining children in placement. (4)

> Federal children's programs are structured and funded in such a way that states face perverse incentives to place children into substitute care rather than to support families: funding for placement prevention and family preservation services is minimal, while funding for placement services is an open-ended entitlement. (78)

> ...if there is a IV-E eligible child in foster care in the State of New Hampshire, the Federal government subsidizes that placement rather generously to the tune of 40 or 50%. When the State decides that child should come home and engages our agency to do the reunification work to reunify that kid with his family, suddenly the state has to pay the full boat. There's absolutely no incentive to reunify those families. It would be cheaper for the State to keep the kids in foster care. (109)

> The reasons for the present inefficient and ineffective system are many, but one is increasingly central: our methods of paying for mental health care. Rather than the children's needs being paramount in deciding whether and what type of treatment will be proffered, treatment decisions are increasingly driven by the health care reimbursement system. This system is forcing hospitalization of children even when there are more effective and less expensive alternatives. The reimbursement system is distorting conceptions of mental health in an attempt to control health costs. It is neither successful in controlling costs or in providing adequate services. (101)

### 2. Claims for foster care services remain unpaid

States' fiscal dilemma in delivering children and family services is further aggravated by the Department of Health and Human Services' delay in paying the federal share of foster care costs under the Title IV-E program. In 1987, DHHS owed states over $400 million in reimbursements. The appropriateness of these claims was not disputed by the Department of Health and Human Services, but nevertheless many remained several years overdue. This delay has placed a fiscal burden on states, as they must absorb, for an indefinite period of time, the federal share as well as the State share of foster care costs. (99, 47)

> As an entitlement program, states are to be fully reimbursed for payments made on behalf of the children in their care. Yet this is not occurring. In Missouri alone [in 1988], HHS is $11.5 million behind in payment of the state's foster care bill. Nationally, APWA [American Public

> Welfare Association] has reported that from the responses of thirty states to date, back claims total more than $400 million....HHS has not treated funding for this program as they do other entitlement programs, and they simply say to the state, 'We know we owe you money, but we don't have any cash. Sorry.' (99)

> States experience cash flow problems due to delays in federal reimbursement for Title IV-E maintenance and administrative claims: grants are awarded consistently late and Minnesota has not received full reimbursement for maintenance or administration since 1985. (43)

The lack of timely reimbursement is one more barrier that states faced while trying to meet the overwhelming demands placed upon children's services. In March 1989, New York State filed a lawsuit seeking to collect an estimated $157 million owed to the State and localities under the Title IV-E program.

Regardless of whether witnesses were describing foster care, mental health or juvenile justice services, improvements in financing mechanisms were identified as essential to making services to vulnerable children and families available, coordinated and effective.

Witnesses called for an increase in federal resources for the child welfare system. To develop an adequate range of family support services which provide the underpinning for a permanency planning strategy, witnesses urged expanded funding through Title IV-B (Child Welfare Services) and Title XX (Social Services Block Grant). (78, 71) One witness indicated that Title IV-B funds should be increased in proportion to Title IV-E expenses to ensure that reunification and preventive efforts are emphasized. (116)

Witnesses also urged additional funding to close the gap between children's mental health needs and available resources. (101, 40, 65)

In addition to expanded funding, witnesses stressed the importance of greater flexibility in the use of available federal monies to meet troubled children's needs. (4, 78, 71) Testimony suggested broadened use of Title IV-E monies to expand efforts to preserve families and prevent placement. This is consistent with the statute's requirement that States make "reasonable efforts" to prevent placement. Funding of these services with Title IV-E dollars could be for a limited time period, and only for children at "imminent risk" of removal. In addition, witnesses urged consideration of using Title IV-E to pay "partial maintenance" or after-care services once the child has returned home. (91, 78, 71, 43, 114) Numerous advocates called for greater funding flexibility in mental health financing as well. (101, 40)

To encourage states to develop and strengthen prevention efforts, witnesses recommended fiscal incentives, including expanding and making permanent the existing mechanism which allows states to transfer foster care maintenance dollars (Title IV-E) to be used for child welfare services (Title IV-B); offering increased federal matching rates to pay for more therapeutic foster care settings; and paying start-up costs for family preservation, therapeutic foster care and transitional living programs on the condition that states agree to support the program for at least two years after federal demonstration funding ends. (116, 4, 1)

### E. Federal Enforcement and Oversight Weak

Throughout these investigations, a consistent theme was the federal government's failure to execute forcefully its responsibilities under current laws affecting troubled families and their children.

At the same time, the Federal officials in charge of foster care programs reported to the Committee in successive years that the federal government was doing an adequate job. (93, 73) According to the Assistant Secretary for Human Development Services in testimony in 1988, "I think the Department has done a good job. More needs to be done."

Citing "considerable progress" child welfare programs "have made over the last eight years," Olson referred to the reported drop in the number of children in foster care from 1977 to 1985 and noted "that the number of children in foster care has increased slightly in the last few years." By contrast, the Select Committee's 10-state survey indicates that the number of children in foster care from 1985 through 1988 has risen by nearly one-quarter.

P.L. 96-272, The Adoption Assistance and Child Welfare Act of 1980, mandates both programmatic and fiscal reviews to ensure that states comply with the requirements of the law, including implementation of the protections and safeguards for children in care. Under the Title IV-E foster care maintenance program, the law requires that states comply with specific provisions in order to be eligible for payments. Among the major provisions are the requirements of "reasonable efforts" to prevent or eliminate the need for removal of a child from his home, to be made prior to the placement of a child in foster care and to make it possible for the child to return to his home; development of a case plan and review system for each child, licensing standards, and goals for children in foster care longer than 24 months.

Under the Title IV-B child welfare services program, the law requires that to receive their share of payments that are made available when total program appropriations exceed $141 million, states must conduct case plan reviews consisting of several components, including an inventory of children in care, an operational statewide information system, a case review system for each child in care, permanency planning and reunification programs.

Testimony to the Select Committee indicated that a lack of federal guidance coupled with flawed and slow-moving federal review processes contribute substantially to lack of planning, services, and successful outcomes for children in out-of-home care. (116, 54, 61, 75) State and local child welfare staff reported considerable confusion and difficulty in implementing the 1980 reform law.

> There is a feeling in the states that we are sometimes alone. Our federal partners, in both the executive and legislative branch, seem to have left us to implement the new foster care and adoption programs without the benefit

> of full federal guidance from the U.S. Department of Health and Human Services. And, although HHS rarely requests adequate funding for child welfare and foster care program, Congress also has not taken the lead in adequately funding these programs, either. (99)

In particular, administrators and advocates alike cited the absence of federal guidance on the implementation and administration of federal/state programs for children in care; lack of guidance about appropriate services and their mix; and failure to design and carry out efforts to ensure quality control. (57, 107, 115, 75)

> Little guidance has been given to the states by the federal government as to the most efficient and effective means of implementing many of the requirements of the law; federal regs which have been issued have been too vague and issued too slowly. (115)

This testimony identified problems very similar to those documented by the GAO and others when the reform law was first enacted. In 1984 for example, the GAO found serious implementation problems in part "because HHS did not provide states timely guidance or require implementation of all of the Act's requirements." (128) At that time, the GAO recommended revision of program regulations "to provide additional guidance and undertake new compliance reviews." (128)

While noting that some improvements in the child welfare system may have resulted from the reform law, a recent review of the 1980 foster care reforms still found "no conclusive evidence on the effects of the reforms" and cited the absence of adequate national and state information and systematic evaluations as impediments to "answer[ing] questions about the intended outcomes of the reforms for children and families.

Witnesses repeatedly testified that the requirement to make "reasonable efforts" -- the core of the law and the premise behind preventive programs -- had not been meaningfully implemented by HHS, and that such efforts have not been made in many cases. (75, 36, 54, 61, 117) In some instances, court officials cited that efforts have been made where in fact none have, in order to move through high caseloads and to continue federal funding. (103, 61)

Witnesses reported that children receive the protection of P.L. 96-272 only on paper because HHS conducts only "paper" audits of these protections. They explained that reviewers look to see if there is a judicial determination that "reasonable efforts" have been made or if the child has a case plan in his file; they do not look beyond the finding or plan to determine if reasonable efforts were actually made, appropriate services provided, or whether states actually follow case plans.

> We do not go beyond to look at whether or not once reasonable efforts are indicated as part of the judicial determination that that placement was necessary and continued placement in the home was contrary to the child's welfare. (12)

> Virginia's experience during compliance reviews by the DHHS has been frustrating at best. We have experienced inconsistency in review standards and procedures from review to review. We are aware that standards for compliance have varied from state to state and year to year....There are, 8 years after the passage of this legislation, still no published review criteria to assist states in coming into compliance....Policy interpretations and notification of policy changes have come long after their scheduled implementation dates....The federal reviews have narrowly focused on technical compliance and have essentially ignored issues of effective service provision. (56)

> ....427 reviews do not focus on the quality of services provided to children and families. (91)

> The federal government has shirked its oversight responsibilities. Although HHS is required to audit a state's compliance with P.L. 96-272, it is almost impossible to fail an HHS audit. (75)

> HHS fails to monitor reasonable efforts requirements and

> the adoption subsidy program, fails to assess whether states' IV-B programs are adequate to meet needs of children and families; many procedural protections have become meaningless bureaucratic rituals. (86)

The law also requires regular fiscal reviews under the Title IV-E program, but these reviews often do not occur in timely fashion and rely on a small number of actual cases to make a determination. (12, 93)

State and local administrators and advocates agreed that the Department of Health and Human Services needs to take a more active role in assessing compliance with P.L. 96-272, especially when assessing the "reasonable efforts" requirement. (86, 75, 116)

The "reasonable efforts" requirement frequently goes unmet, according to many witnesses before the Committee.

> Many states have yet to enact legislation requiring judges to adhere to P.L. 96-272, and some state court judges resist Congressional dictates regarding how they should do their jobs.

> Enforcement of the Reasonable Efforts requirement depends then on a process that is often significantly flawed. Not only is the process flawed because of the inadequacies or the inherent limitations of the various players, or because of the way courts are organized, but it is deficient in other ways as well....In too many places, particularly in large urban areas like New York, Chicago and Los Angeles, hearings and reviews in abuse and neglect proceedings are brief and perfunctory. (61)

Judge Jones noted further that "fiscal incentives of the Act flow exclusively to social services agencies," and called for "congressional incentives to courts for fulfilling the reasonable efforts mandate and to states for enhancing the quality of advocacy and decision making in abuse and neglect." He told the Committee that "already overburdened courts have no fiscal incentive and, except for judges who are committed to serving children and families better, no other reason to take serious the

Reasonable Efforts requirement."

A recent GAO study on foster care also called for the federal government to strengthen efforts to determine and ensure compliance with the reform law. The study, which assessed the effectiveness of foster care reforms and focused on compliance with Section 427 requirements, recommended setting higher standards for certifying states' compliance. (143)

Witnesses cited inadequacies in federal enforcement of juvenile justice program requirements as well. Testimony reported that the Office of Juvenile Justice and Delinquency Prevention has not enforced the ban on putting children in adult jails and generally has conducted little monitoring of state activity.

> There has been a failure of leadership at the Federal level, particularly in the area of juvenile justice. The Office of Juvenile Justice and Delinquency Prevention squanders its money on bizarre projects like the study of cartoons and pictures in back issues of Playboy, Penthouse, and Hustler, while putting enforcement of the Juvenile Justice Act's prohibition against jailing children on the back burner. In the past five years, the OJJDP has made no real effort to monitor state compliance with the federal law. Local officials throughout the country have told me that despite open violations of the Act, they have no fear of federal audits or funding cutoffs. (107)

### F. Essential Data Unavailable

The lack of credible data about children in care and the services they receive was reported as a major barrier to effective administration of child welfare, juvenile justice and mental health policies.

> We really don't know much about these children. We don't have accurate counts of how many children are in foster care. We don't have accurate counts of how many special needs children are adopted. Clearly, what we need is accurate data. And in order to make any kind of accurate kind of policy decisions on these children -- we have heard

> a lot today about the need for accountability -- we just can't get it without accurate data. (100)

Specifically, witnesses indicated that the lack of adequate data systems prevents understanding who the children are in the various state care systems; impedes the development of long term plans; and blocks the identification of service gaps and system weaknesses which can then be corrected. Recent budget constraints only reinforce the need for reliable data to evaluate program effectiveness. One witness pointed out that in Los Angeles, the lack of data prevents determining which programs are working and therefore should be extended or receive additional resources. (5)

The lack of accurate information about even the basic numbers of children in out-of-home care is particularly alarming because P.L. 96-272 included clear data collection mandates. Ten years after the law's passage, the only national count of children in foster care comes from a voluntary system -- Voluntary Cooperative Information System (VCIS) -- operated by the American Public Welfare Association.

> The big problem with this is that it is voluntary. Most of the data that we have on these children, even the APWA report says, 'must be considered as rough national estimates.' I think the more than 260,000 in foster care, and at least 36,000 of these that are waiting to be adopted in this country, are much too important to rely on rough national estimates based on data that the states choose to submit. (100)

Even when the Select Committee requested the most current data directly from selected states, not all were able to provide the total number of children in placement through 1988.

This lack of data contributes to difficulties in determining states' compliance with the federal law. Without data, it is impossible to determine what, if any, progress has been made in either returning children to their families or finding them permanent homes. As one witness stated "we will not be able to properly document progress on behalf of waiting children until we are able to count them accurately." (66)

The 1986 Budget Reconciliation Act (P.L. 99-509) mandated several studies and reports to the Congress related to the feasibility of and elements of a system for the collection of data. By July 1, 1988, the Department of Health and Human Services was to report to Congress its recommendations for data collection, including its establishment, administration, and financing. The Department submitted its proposal to the Congress in May 1989. The report proposes a uniform computerized method for states to collect foster care and adoption information and to report those data to the federal government. (126)

The GAO has concurred in the finding of inadequate information about the foster care program. In its recent assessment of foster care reforms, GAO concluded that

> Neither the required state information systems nor the recommended national system includes the quality-of-care data needed to answer questions about the intended outcomes of the reforms for children and families. A national information system, as required by Public Law 99-509 but not yet implemented by HHS, could correct the inconsistency of the states' definitions, which limits the utility of current systems for research and oversight. (143)

GAO recommended that the Secretary of HHS promptly comply with the mandates regarding development of a national information system on adoption and foster care, noting that "such a system is a critical first step for informing the Secretary and the Congress about the efficiency and effectiveness of the program. GAO also suggested that Congress may want to consider mandating specific evaluations of the effects of the reform law.

Efforts to collect up-to-date mental health information as part of this assessment revealed how untimely and inexact data are on children in the mental health system. The most current information obtained was for 1986.

> A major difficulty...in designing more effective children's mental health programs was the lack of data on many

> treatment regimens and service systems. Although NIMH commits approximately 20% of its current research budget to children's issues, available dollars have not kept pace with assessments of the funds necessary. Most mental health care interventions are appropriate for evaluation studies -- most could benefit from the information that research provides. In addition, basic information about the characteristics and utilization of the contemporary mental health service system is not available. The financial savings from a more comprehensive data base are potentially enormous; the benefits to children and society of more effective programs are incalculable. (133)

Data limitations exist in the juvenile justice area as well. While the Justice Department can provide information on juveniles in public and private facilities, the statistics on private facilities remain incomplete and are still being processed. Moreover, this census does not include youth who are confined in adult jails and lock-ups. Such information is needed in order to obtain a complete understanding of the juvenile population in confinement.

Collection of adequate and timely information was a priority highlighted by numerous witnesses. Specific recommendations included federally mandating that states track the number of children entering care, the duration of placements and the costs of care, as well as providing documentation of the reasons for foster care placements. (1, 116)

Further recommendations from witnesses emphasized that data collection should cover all systems of care and should require cost projections for at least five years into the future. As an immediate step in the foster care system, witnesses suggested requiring child welfare agencies to specify, in their IV-B and IV-E plans, the numbers of children who will be provided care under these programs. (1)

# CHAPTER III. PROMISING PROGRAMS TO PREVENT PLACEMENT

## A. Prevention and Early Intervention Less Costly, More Effective

The Select Committee's continuing examination of children in state care has revealed numerous effective and promising programs that assist vulnerable children and families. From health care to social service needs, from infancy through adulthood, researchers and providers increasingly recommend efforts that emphasize early rather than later intervention. They also advocate providing services to children in a coordinated, comprehensive fashion, and in a home setting wherever possible.

A wide range of child welfare experts testified to the value of prevention and early intervention in eliminating or reducing problems that, left unattended, become much more complex, difficult and costly.

Rather than concentrating funds on investigations and treatment, "we need to understand that pouring resources into investigations is a losing, if necessary venture. We have got to begin to invest substantially in the development of alternatives that can strengthen families, restore stability, and hopefully, prevent abuse from occurring. Children belong with their families, but if we are going to keep them there, we have got to find a way to ameliorate the conditions that lead to dysfunction and disintegration." (77)

Witnesses consistently report the effectiveness of preventive approaches to reducing conditions that can lead to family crises and instability, including reducing low birthweight births, as well as avoiding infant health and nutrition problems (83); substance abuse (9); teen pregnancy (63, 83); child abuse (22, 37, 42, 63); academic failure, dropping out of school, juvenile delinquency, and unemployment (52, 42).

Testimony emphasized that effective prevention and early intervention strategies are not just limited to efforts with infants and young children.

> Adolescence [is] an absolutely critical time for preventive intervention, very much neglected until recent years....[This] is a formative time, while...behaviors are being explored, while they are still tentative, before they are cast in concrete. It's a crucial opportunity for preventive intervention, to change behavior for health, to shape behavior toward health-promoting directions. It's also a crucial period for educational success. (52)

## B. Growing Support for Family Preservation and Community-based Services

Toward the goal of averting crises and the need for out-of-home placement, "family preservation" (i.e., intensive, in-home crisis intervention programs) and other family-based services designed to maintain children safely in their homes and in their communities are gaining increasing support.[12] These effective programs aim to keep families intact, when possible, rather than placing children in out-of-home care. Family preservation services are typically provided in the home, and caseworkers have low caseloads in order to provide intensive services. (90, 33, 140)

> Family based services are a fairly new, rapidly growing area of child welfare services in which the focus is on the whole family, not on individual members of the family; in which services are provided intensively, that is at least 1 to 2 hours a week, minimum, face-to-face contact with the family; which are generally short-term, lasting no longer than 3 to 6 months and which are enabled by low caseloads averaging about 10. (90)

> [While] Family Preservation does not address the underlying

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[12] Testimony of Peter Forsythe (reference no. 38) and publication Keeping Families Together: The Case for Family Preservation (reference no. 149) discuss the history and rationale for "family preservation" programs.

> reasons for the increasing numbers of vulnerable children and families that American society is producing...it is a very significant contribution to caring for these families. We strongly urge this Committee to make every effort to ensure that, before we spend tens of thousands of dollars on long-term placements of vulnerable children, we ensure that a few thousand dollars can be spent to make every reasonable effort to keep their families intact. (70)

A number of states and local communities have begun to develop and expand these programs with impressive results so far:

**Washington and Utah** A recent study of family preservation programs in these states showed that of the group of children who did not receive family preservation services 69% were placed out-of-home; of those who received services, 68% remained in their own homes or with relatives.[13] (140)

**Maryland** Maryland's Intensive Family Services' model features time-limited, intensive home-based family-centered services with families who are in crisis and who are at risk of placement. A social worker and parent aide, with consultation as needed from a family therapist, work with the families over a 90-day period. Workers have "flexible dollars" to use for immediate needs or emergencies such as housing or other specialized services.

> Families who participate in IFS show a much lower rate of out-of-home placement than do those who receive the traditional service delivery, both at entry into services and at termination....[Of 160 families served, 9 placements (6%) were required at entry and 3 placements were required at service closure (2%) as compared with 125 of 316 (40%) of cases requiring placement at entry and 29 of 192 (15%)

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[13] All the children in this study were slated for out-of-home placement.

requiring placement at case closure (after 6 months) using traditional services.] The annual cost of providing service to 1,000 children in foster care is estimated at $8.5 million compared with $2.3 million of IFS services, for a cost savings of $6.2 million for every 1,000 children receiving IFS. (58, 29)

**Virginia** Virginia's efforts began in the 1980s by offering 18-month grants to the local public and private nonprofit agencies and organizations to strengthen and maintain families and to prevent or eliminate the need for out-of-home placement of children into foster care or residential facilities. The grants demonstrated beyond a doubt that prevention of out-of-home placement was cheaper, both in the short term and long term....For example, of the 715 children at risk for foster care placement, only 7% left their homes and were placed in foster care. In addition, an evaluation of the level of family functioning at the beginning and the end of the service delivery periods revealed that 69% of the families improved in overall family functioning during the project. The bottom line on the pre-placement prevention grants reflected an average cost per child of $1,214 to prevent placement, compared with an average cost per child of $11,173, just for room and board, for a child in foster care for 4.6 years, which is our State average. Thus, family-focused prevention services are both cost effective and ethically recommended. (56)

**New Hampshire** Familystrength's family-centered, in-home services is short term and time limited. Families receive intensive services for a maximum of 6 months. The maximum counselor caseload is four to five families and the agency is on call to all families 24 hours a day, 7 days a week for maximum flexibility and emergency assistance and work is comprehensive. "One key reason for this model's success is the powerful combination of therapy and assistance in meeting basic, concrete needs. We view the model as a hybrid of family counseling, social work, and education. Treatment plans are designed to meet the specific needs of each family and our interventions vary greatly from family to family....Studies show that most families can learn to make changes significant enough so that placement becomes unnecessary. Of the approximately 180 families served this past year, 88% made measurable gains in one or more major goal area. A preliminary review of our 1986-87 data, which is incomplete as of yet, indicates that of the families terminated during the year, 76% were intact at the end of treatment, 12% were placed temporarily and with support, and will likely be returning home on a more long-term basis. The average length of treatment was 4.4 months, at an average cost of $4,800 per family of five. This is less than half the average cost of placement for one child for one year. (109)

**New Orleans, LA** Kingsley House Family Preservation Services provides intensive home-based services to keep families together and children safe. These services include crisis intervention within twenty-four hours of referral; in-home counseling and therapy; crisis resolution; flexible hours; networking and referrals to other agencies; and follow-up. Since October 1985, the program has provided services to 106 families, including 389 children and 166 adults, at a cost of $2,500 per family or less than $700 per child. It is estimated that the family preservation program has saved the State nearly $1 million because of averted foster care placement costs.

**Vermont** Between FY 1984 and FY 1987, at the same time the State's child population decreased, the substitute care population increased by 21% statewide. However, two districts that provided state-funded intensive family-based services experienced a 120% decrease in out-of-home placement. The statewide cost savings is estimated to be $1.24 million." (140)

Prevention of unnecessary out-of-home placement is a salient issue in the juvenile corrections field as well. There are no simple answers to the issues of youth crime and corrections. A balance must always be struck between the interests of public safety and the needs of individual youth for treatment and rehabilitation. However, State and local criminal justice agencies and policy makers are exploring front-end, preventive approaches to solving their juvenile crime problems -- recognizing that overreliance on incarceration will result in misuse of scarce resources.

> Resource allocation must be carefully examined and, to the extent possible, resources must be allocated to programs and services that have the most potential for effectively addressing youth crime. In particular, prevention and early intervention programs that focus upon family and school problems utilizing community-based resources must receive greater financial assistance if we are to maximize the value of the public's investment in this system. (155)

In the juvenile justice system, a small but growing number of states are shifting their juvenile justice monies away from large institutions and into community-based programs. Although it is recognized that some juvenile offenders will require secure placement, experts believe that the overwhelming majority of these youth can be treated effectively and safely through a continuum of community-based programs that provide services ranging from traditional counseling and probation to intensive supervision and offender tracking. (155, 177)

Massachusetts, Utah, Florida, and Maryland have found such community-based programs not only to be effective in working with delinquent youth but also to be cost effective. Florida, for example, found that institutional beds cost approximately twice as much to support from public funds as community-based beds and that much of the higher costs of institutional programs is tied to administrative and physical plant expenses that do not directly impact upon effective programming with delinquent youth. (155)

In 1987 and 1988, the State of Maryland closed the

Montrose juvenile training school, a facility that had been in operation almost 70 years, and released over two hundred youths. Approximately half were released with services and supervision in their own homes. Most of the others were placed in smaller, non-secure residential programs. Preliminary follow-up studies have suggested that less than fifteen percent of these youth have been re-incarcerated.

## C. Comprehensive, Coordinated and Integrated Children's Services Urged

In addition to a focus on prevention and early intervention, there has been growing interest in efforts to coordinate services for children across the multiple agencies whose help may be required.

> Family preservation services operate best when they are part of a broader spectrum of child welfare services, and are linked to the specialized health, mental health, education, and social services that may be needed by families being served. States implementing these services thus need to give attention to how they fit within their overall continuum and to the specific, operational linkages that must be developed between these services and other pre-existing services. (33)

The typically complex and multiple problems evidenced by children in state care and their families require a multifaceted and integrated response.

> Essentially, there has to be increased recognition that overall the need is not for one or two particular magic services but rather for an overall system of care that provides a range of services, flexibility to tailor services to meet individual needs, that is community based and family focused, is balanced between the more and less restrictive services, and is interagency in focus. (40)

Even within a particular health or child welfare system, there is increasing awareness of the interrelatedness of needs and the necessity of fashioning special services that are flexible enough to work with other resources.

> Traditional social services such as homemaker assistance, child care, counseling and parenting skills training are no longer sufficient to assist those families facing placement. A full continuum of family support services is also imperative. (121)

According to one mental health expert,

> The complex child-environment relationship....suggests the need for multiple forms of treatment and interventions that address both the child and the child's context. It argues against an emphasis on diagnosis-based systems which establish treatment planning on the symptomatology of the child. It argues for a multi-layered coordinated system of care with an emphasis on prevention of mental health problems. (101)

One important effort aimed at better service coordination is the Child and Adolescent Service System, or CASSP, a small federal program which provides incentives for states to develop "....a comprehensive and integrated planning process for services to children with mental health needs." Through CASSP, 47 states have begun to combine the resources of their educational, juvenile justice, social welfare, health, and mental health systems to set up a wider range of services to address the needs of troubled youth. As a result,

> ...there is considerably more focus on this population of children, more interagency planning, and a more uniform approach to planning for individualized treatment services....The votes are not in yet, however, on how effectively such planning can be translated into real services to real children. (7)

> CASSP is [also] important because it, first of all, is serving as a catalyst to the states to provide some leadership on children's mental health; secondly, because it requires the states to develop some real interagency efforts; and third, it calls on states to develop what we have come to think

> about as systems of care, to provide the range of services that we know we need to have in different communities if children are to be effectively served, and particularly to provide some of the nonresidential services that we are beginning to see really can make a difference; what we call in child welfare, family preservation services, and day treatment programs. All of these are absolutely essential, and we have some evidence that they really can make a difference for very troubled children. (65)

Another model interagency children's mental health system has been developed in Ventura County, California. This effort provides a system of services and care to children and families at imminent risk of separation. Family and community-based services have been designed to promote family preservation, whenever possible, and if necessary, provide out-of-home placement of short duration. The program is characterized by integrated, interagency services with coordinated and "blended" funding.

The results of the program have been dramatic in lowering the rate of out-of-home placement and offsetting more than 50% of its costs.

> Specifically, Ventura County has reduced state hospital use to 25% of the statewide average for children and youth. To date [7/87], annual savings average $428,000, offsetting 31% of the project's yearly cost....Since June 1985, Ventura has reduced out-of-county, court-ordered juvenile justice and social service placements from 89 to 48, a 46% reduction; AFDC/FC placement costs have declined 11%...an annual savings of $226,000, offsetting 16% of the project's cost. With statewide implementation, the projected savings in AFDC/FC costs alone would be $22 million...[R]eincarceration of mentally disordered juvenile offenders was reduced 47%, a potential savings of $385,000-...[C]ounty has only four handicapped special education pupils placed pursuant to Public Law 94-142 in residential nonpublic school placement. This is 20% of the statewide average. This difference in public sector costs between Ventura County and the statewide average equals $480,000

per year. (34)

### D. Increasing Interest, But Still Few Programs and Little Support

Despite the promise and actual success of intensive family-based services and comprehensive and coordinated services, they remain few and unable to meet the need.

> We do not have enough ICCP [Intensive Crisis Counseling Program] projects in Florida to meet the need for this type of service. We could easily quadruple the number of projects we have and still not have enough. This model can be used to serve a number of client populations -- delinquent children, children in foster homes and adoptive homes and children with a broad range of mental health problems. We think it would be particularly effective in preventing disruptions in foster care and adoptive placements. Our current policy allows the program to be used for some of these children now, but as a practical matter there simply aren't enough ICCP projects to meet the need. (94)

While many states and local communities have developed interest in and begun to support model efforts, very little federal funding has been available to states for these activities. Rather, as discussed in Chapter III, the major federal funding under Title IV-E of the Social Security Act provides funding for maintenance of AFDC-eligible children in foster care.

There remains a significant lack of coordinated services and the funding to support such efforts. For example, as of the end of FY 1989, CASSP funded grants in 47 states, the District of Columbia and the Virgin Islands at a total funding level of $9.8 million. In contrast, foster care maintenance costs were estimated to exceed $1 billion.

# APPENDIX I

## TABLES

## TABLE 1

## FOSTER CARE TRENDS IN SELECTED LARGE STATES 1980, 1985-1988[a]

| STATE | 1980 | 1985 | 1986 | 1987 | 1988 | Trend 80-85 | Trend 85-88 |
|---|---|---|---|---|---|---|---|
| California | 27,534 | 43,344 | 48,824 | 54,360 | 62,419 | 57% | 44% |
| Florida | 9,922 | 6,766 | 6,802 | 7,017 | 7,725 | -32% | 14% |
| Illinois | 14,302 | 14,643 | 14,472 | 15,829 | 17,425 | 2% | 19% |
| Michigan | 8,686 | 8,455 | 8,566 | 9,791 | 11,302 | -3% | 34% |
| Missouri | 7,492 | 6,303 | 6,452 | 6,202 | 6,376 | -16% | 1% |
| New Jersey | 10,275 | 8,983 | 8,840 | 8,681 | 8,542 | -13% | -5% |
| New York | 40,762 | 26,022 | 27,504 | 29,404 | 33,645 | -36% | 29% |
| North Carolina | 8,531 | 6,575 | 6,254 | 6,124 | 6,126 | -23% | -7% |
| Ohio | 17,663 | 12,990 | 13,079 | 13,000 | 13,100 | -26% | 1% |
| Pennsylvania | 14,652 | 12,901 | 13,185 | 13,751 | 14,797 | -12% | 15% |
| Texas | 6,818 | 4,851 | 4,727 | 4,769 | 5,449 | -29% | 12% |
| 11 State Total | 166,637 | 151,833 | 158,705 | 169,028 | 186,906 | -9% | 23% |
| U.S. Total | 303,500 | 276,300 | 289,000 | 307,750 | 340,300 | -9% | 23% |
| 11 State/ US Total | 0.5491 | 0.5495 | 0.5492 | 0.5492 | 0.5492 | | |

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[a] Sources and notes: see following pages.

## Foster Care Trends: 1980, 1985 - 1988
## Sources and Notes

1. 1980 data were obtained from Office for Civil Rights, DHHS, Children and Youth Referral Survey: Public Welfare and Social Service Agencies, 1981.

2. 1985 data were obtained from the Child Welfare Statistical Fact Book, 1985: Substitute Care, Maximus, Inc., 1988.

3. 1986-1988 data were obtained from a telephone survey of ten states with large foster care populations and from a special study for Missouri, Where's My Home - A Study of Missouri's Children in Out-of-Home Placement, January 1989.

4. The following adjustments were made to state data:

   a. Illinois - the 1980 figure of 11,480 was increased to 14,302 to include children in relatives' home for comparability with data for other years.

   b. Michigan - the 1985 and 1986 data were adjusted to exclude children supervised in-home with legal guardian using the VCIS data. This was estimated for 1980 data using 1985 proportion.

   c. New Jersey - the 1985 and 1986 data were adjusted to include all children in foster care and not those solely in foster family homes based on data provided by New Jersey.

   d. New York - the 1988 number of children in foster care was 45,445 including 11,800 in approved relative homes. The latter were excluded and 33,645 children were reported as being in foster care for comparability with the 1985 figure.

   e. Ohio - the 1988 estimate was not provided and after discussion with Douglas Oxenford, Data Coordinator, Ohio, an assumption was made that it was similar to the figure reported for 1986. The 1985 total of 9,139 children was changed to 12,990 based on the 1986 VCIS data reported for the first day of 1986 (which should equal the last day of 1985) as the original figure was inconsistent with all other data for Ohio.

Due to changes in definitions and state information systems between 1982 and 1985, the trend analysis between 1980 and 1985 should be viewed with some caution. The data from 1985 and after are more reliable, complete, and free of much of the duplicated counts in earlier data. However, these data still are based on many different definitions of foster care and different reporting periods.

5. Total foster care population in 1988 was estimated by two methods:

   a. The 23.1 percent increase between the totals for the 11 states from 1985-1988 was applied to the 1985 total 276,300 children for all states and the District of Columbia and Puerto Rico. The 1988 estimate was 340,100 children in foster care.

   b. The average proportion of children in foster care for the 11 states in comparison to the total number of children in foster care for 1980, 1985 and 1986 was applied to the number in care for 1988 to obtain a total for the entire country. The average proportion for the three years was .5492 based on the following: 1980-.5491, 1985-.5495, and 1986-.5492. The 1988 estimate was 340,300 children in foster care.

      This estimation method is mathematically equal to the other method when the proportion for 1985 is identical to the average proportion for the three years. The greater the disparity in these two figures, the greater the disparity in the two national estimates. As the 1985 proportion of .5495 is very close to the average proportion of .5492, the national estimates differ by only 200 children out of 340,000.

Either of the two estimates, 340,100 or 340,300, reflect both a marked increase in the number of children in foster care as well as the rapidly increasing percentage of children in care living in California. California accounted for 16.5% of the total children in foster care for the 11 states in 1980 and this doubled by 1988 to 33.4%. For the total number of children in foster care nationally, the percentage increased from 9% in 1980 to 18 percent by 1988. Nearly one out of five children in foster care lives in California in 1988.

The above estimates do not include many children living in approved relatives' homes. This type of living arrangement appears to be growing rapidly due in part to prority for placements in a "least restrictive environment" as well as economic considerations. The relative's home is paid the regular foster home board rate through a combination of state, federal or local funds. There may be between 22,000 and 30,000 children living with relatives that are not included in the national estimates noted above.

6. Assistance in the analysis of the survey data was provided by Dr. Charles Gershenson and the Center for the Study of Social Policy.

## TABLE 2

## NUMBER OF CHILDREN ENTERING AND LEAVING FOSTER CARE IN TEN MOST POPULOUS STATES, 1985-1988[a]

| State | | 1985 | 1986 | 1987 | 1988 |
|---|---|---|---|---|---|
| California | entering | 25,749 | 30,090 | 31,780 | 32,387 |
| | exiting | 20,492 | 20,312 | 20,842 | 21,392 |
| Florida | entering | 3,251 | 3,457 | 4,840 | 5,341 |
| | exiting | 4,159 | 3,418 | 4,855 | 4,505 |
| Illinois | entering | 6,936 | 7,209 | N/A | N/A |
| | exiting | 3,524 | 3,829 | N/A | N/A |
| Michigan | entering | 4,850 | 5,783 | 5,682 | 6,081 |
| | exiting | 4,018 | 4,604 | 4,457 | 4,570 |
| New Jersey | entering | 5,100 | 4,221 | 4,009 | 3,849 |
| | exiting | 5,045 | N/A | N/A | N/A |
| New York | entering | 13,854 | 15,954 | 17,012 | N/A |
| | exiting | 14,178 | 15,886 | 14,637 | N/A |
| N. Carolina | entering | 2,635 | 2,604 | 2,654 | 2,710 |
| | exiting | 3,009 | 2,828 | 2,781 | 2,744 |
| Ohio | entering | 5,203 | 8,860 | N/A | N/A |
| | exiting | 7,159 | 8,745 | N/A | N/A |
| Pennsylvania | entering | N/A | N/A | N/A | N/A |
| | exiting | N/A | N/A | N/A | N/A |
| Texas | entering | 3,241 | 4,539 | N/A | N/A |
| | exiting | 3,266 | 3,796 | N/A | N/A |

---

[a] Source 1986-1988 data: Select Committee on Children, Youth and Families 10-State Substitute Care Survey, 1989; 1985 data from State Child Welfare Abstracts 1980-1985, prepared for DHHS, December 1987.

## TABLE 3

## JUVENILES IN CUSTODY IN PUBLIC AND PRIVATE FACILITIES, 1975-1987[a]

| | 1975 | 1977 | 1979 | 1983 | 1985 | 1987 | %change 1979-85 | %change 1979-87 | %change 1985-87 |
|---|---|---|---|---|---|---|---|---|---|
| **# of Juveniles in Custody:** | | | | | | | | | |
| Total | 74,270 | 73,166 | 71,922 | 80,091 | 83,402 | 91,646 | 16% | 27% | 10% |
| Public Facilities | 46,980 | 44,096 | 43,234 | 48,701 | 49,322 | 53,503 | 14% | 24% | 8% |
| Private Facilities[b] | 27,290 | 29,070 | 28,688 | 31,390 | 34,080 | 38,143 | 19% | 33% | 12% |
| **Juv. Custody Rate per 100,000:** | | | | | | | | | |
| Total | 241 | 247 | 251 | 290 | 313 | 353 | 25% | 41% | 13% |
| Public Facilities | 152 | 149 | 151 | 176 | 185 | 208 | 23% | 38% | 12% |
| Private Facilities | 89 | 98 | 100 | 114 | 128 | 145 | 28% | 45% | 13% |
| **# of Juvenile Facilities** | | | | | | | | | |
| Total | 2,151 | 2,592 | 2,572 | 2,900 | 3,036 | 3,302 | 18% | 28% | 9% |
| Public Facilities | 874 | 992 | 1,015 | 1,023 | 1,040 | 1,107 | 2% | 9% | 6% |
| Private Facilities | 1,277 | 1,600 | 1,561 | 1,877 | 1,996 | 2,195 | 28% | 41% | 10% |

---

[a] Source: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

[b] Data for private juvenile facilities are based on an 80% survey response rate.

## TABLE 3 (Cont'd)

| | 1975 | 1977 | 1979 | 1982 | 1984 | 1987 | %change 1979-84 | %change 1979-87 | %change 1985-87 |
|---|---|---|---|---|---|---|---|---|---|
| Admissions to Juv. Facil. | | | | | | | | | |
| Total[c] | 697,897 | 681,430 | 638,309 | 612,781 | 622,614 | 716,608 | -2% | 12% | 15% |
| Public Facilities | 641,189 | 614,385 | 568,802 | 523,975 | 521,607 | 590,654 | -8% | 4% | 13% |
| Private Facilities | 56,708 | 67,045 | 69,507 | 88,806 | 101,007 | 125,954 | 45% | 81% | 25% |
| Discharges | | | | | | | | | |
| Total | 674,969 | 683,722 | 625,325 | 600,858 | 611,307 | 705,397 | -2% | 13% | 15% |
| Public Facilities | 623,983 | 622,151 | 560,751 | 516,459 | 515,301 | 585,437 | -8% | 4% | 14% |
| Private Facilities | 50,986 | 61,571 | 64,574 | 84,399 | 96,006 | 119,960 | 49% | 86% | 25% |
| Total Operating Expenses (in billions of dollars)[d] | | | | | | | | | |
| Total | .86 | 1.09 | 1.31 | N/A | N/A | N/A | N/A | N/A | N/A |
| Public Facilities | .59 | .71 | .84 | 1.11 | 1.25 | 1.46 | 49% | 74% | N/A |
| Private Facilities | .27 | .38 | .47 | N/A | N/A | N/A | N/A | N/A | N/A |

---

[c] Data for admissions and discharges (except 1975) represent totals in previous year.

[d] Recent data on the operating expenses of private juvenile facilities not available.

## TABLE 4

## CHILDREN IN OUT-OF-HOME PLACEMENT FOR EMOTIONAL PROBLEMS, 1983 AND 1986[a]

| | 1983[b] | 1986[c] | %change |
|---|---|---|---|
| Inpatient care in hospital | 12,354 | 25,321 | 105% |
| Residential treatmt ctr.[d] | 19,215 | 25,334 | 32% |
| Residential supportive care | 2,491 | 4,061 | 63% |
| TOTAL | 34,060 | 54,716 | 61% |

---

[a] Location of the children being served, and the number of children per setting.

[b] NIMH, series CN #11, Specialty Mental Health Organizations in the United States, 1983-1984, Department of Health and Human Services, 1986.

[c] Unpublished provisional data, Survey and Reports Branch, Division of Biometry and Applied Sciences, NIMH.

[d] Defined as: overnight mental health care in conjunction with supervised living and other supportive services in a setting other than a hospital, e.g., halfway houses, community residences, and group homes. This number reflects only those facilities which are not free-standing (actual number of children in these setting is higher).

## TABLE 5

## CHILD ABUSE AND NEGLECT REPORTING RATES ANNUAL PERCENTAGE CHANGE, 1986-1988[a]

Total number reported cases 1986-1988: 2.2 million

| State | 1986-1987% | 1987-1988% |
|---|---|---|
| Alabama | +4 | +9 |
| Alaska | N/A | N/A |
| Arizona | +1 | +9 |
| Arkansas | +1 | +1 |
| California | +7 | +26[b] |
| Colorado | +11 | +23[b] |
| Connecticut | +9 | +10 |
| Delaware | N/A | N/A |
| District of Columbia | +6 | +1 |
| Florida | 0 | +14 |
| Georgia | +26 | -33[b] |
| Hawaii | -2 | -6 |
| Idaho | 0 | +1 |
| Illinois | +30 | +3 |
| Indiana | -10 | +5 |
| Iowa | -1 | +4 |
| Kansas | +25 | -12 |
| Kentucky | +8 | +5 |
| Louisiana | -14 | 0 |
| Maine | -14 | N/A |
| Maryland | +5 | +6 |
| Massachusetts | +10 | +17 |
| Michigan | -2 | +1 |

---

[a] Dramatic increases or decreases in the number of reports for a given state may be reflective of changes in definitions or procedures rather than changes in actual rates of maltreatment.

[b] Estimate

TABLE 5 (Cont'd)

| State | 1986-1987% | 1987-1988% |
|---|---|---|
| Minnesota | N/A | N/A |
| Mississippi | +18 | +9 |
| Missouri | +1 | -8 |
| Montana | +6 | +7 |
| Nebraska | -3 | -1[b] |
| Nevada | +3 | N/A |
| New Hampshire | +9 | +3 |
| New Jersey | 0 | +13 |
| New Mexico | -3 | N/A |
| New York | +10 | +17 |
| North Carolina | +19 | +4 |
| North Dakota | N/A | N/A |
| Ohio | +1[b] | +1[b] |
| Oklahoma | +14 | +1 |
| Oregon | +3 | +5 |
| Pennsylvania | -2 | +9 |
| Rhode Island | -2 | +10 |
| South Carolina | -2 | 0 |
| South Dakota | +6 | +2 |
| Tennessee | N/A | N/A |
| Texas | -4 | -3 |
| Utah | -1 | -1 |
| Vermont | -9 | +7 |
| Virginia | 0 | +5 |
| Washington | -8 | -23 |
| West Virginia | +1 | +3 |
| Wisconsin | +2 | N/A |
| Wyoming | +12 | +1[b] |
| Average change in percent | +3% | +3% |

## TABLE 6

## TRENDS IN CHILD ABUSE REPORTING BY STATES, 1981-1985[a]

| State | Child Reports 1981 | Child Reports 1985 | Difference | % Change |
|---|---|---|---|---|
| Alabama | 18,654 | 31,385 | 12,731 | 68.2% |
| Alaska | 7,748 | 13,332 | 5,584 | 72.1% |
| Arizona | 7,892 | 43,043 | 35,151 | 445.4% |
| Arkansas | 14,393 | 20,081 | 5,688 | 39.5% |
| California | 179,735 | 272,953 | 93,218 | 51.9% |
| Colorado | 10,908 | 13,825 | 2,917 | 26.7% |
| Connecticut | 10,180 | 16,804 | 6,624 | 65.1% |
| Delaware | 4,741 | 8,051 | 3,310 | 69.8% |
| Dist.of Col. | 5,113 | 6,073 | 960 | 18.8% |
| Florida | 68,446 | 130,393 | 61,947 | 90.5% |
| Georgia | 22,763 | 45,489 | 22,726 | 99.4% |
| Hawaii | 2,635 | 4,069 | 1,434 | 54.4% |
| Idaho | 9,578 | 13,640 | 4,062 | 42.4% |
| Illinois | 47,586 | 68,203 | 20,617 | 43.3% |
| Indiana | 21,929 | 33,868 | 11,939 | 54.4% |
| Iowa | 24,349 | 25,534 | 1,185 | 4.9% |
| Kansas | 19,492 | 23,592 | 4,100 | 21.0% |
| Kentucky | 28,266 | 34,839 | 6,573 | 23.3% |
| Louisiana | 29,406 | 35,802 | 6,396 | 21.8% |
| Maine | 6,714 | 10,121 | 3,407 | 50.7% |
| Maryland | 11,698 | 19,394 | 7,696 | 65.7% |
| Massachusetts | 30,525 | 47,060 | 16,535 | 54.2% |
| Michigan | 57,235 | 95,114 | 37,879 | 66.2% |
| Minnesota | 13,205 | 22,046 | 8,841 | 67.0% |
| Mississippi | 5,881 | 13,921 | 8,040 | 136.7% |

---

[a] Source: Select Committee on Children, Youth, and Families, Abused Children in America: Victims of Official Neglect, 1987

TABLE 6 (Cont'd)

| State | Child Reports 1981 | Child Reports 1985 | Difference | % Change |
|---|---|---|---|---|
| Missouri | 53,722 | 75,953 | 22,231 | 41.4% |
| Montana | 5,243 | 5,516 | 273 | 5.2% |
| Nebraska | 7,013 | 13,765 | 6,752 | 96.3% |
| Nevada | 6,354 | 11,144 | 4,790 | 75.4% |
| New Hampshire | 4,478 | 6,517 | 2,039 | 45.5% |
| New Jersey | 23,758 | 47,126 | 23,368 | 98.4% |
| New Mexico | 5,904 | 12,061 | 6,157 | 104.3% |
| New York | 106,295 | 139,032 | 32,737 | 30.8% |
| North Carolina | 27,017 | 27,625 | 608 | 2.2% |
| North Dakota | 2,944 | 4,719 | 1,775 | 60.3% |
| Ohio | 27,248 | 65,965 | 38,717 | 142.1% |
| Oklahoma | 12,283 | 20,275 | 7,992 | 65.1% |
| Oregon | 2,732 | 12.765 | 10,033 | 367.2% |
| Pennsylvania | 13,703 | 20,980 | 7,277 | 53.1% |
| Rhode Island | 3,784 | 11,196 | 7,412 | 195.9% |
| South Carolina | 19,289 | 28,861 | 9,572 | 49.6% |
| South Dakota | 4,890 | 8,913 | 4,023 | 82.3% |
| Tennessee | 44,146 | 47,050 | 2,904 | 6.6% |
| Texas | 81,819 | 108,561 | 26,742 | 32.7% |
| Utah | 5,832 | 18,089 | 12,257 | 210.2% |
| Vermont | 2,072 | 4,452 | 2,380 | 114.9% |
| Virginia | 39,685 | 49,765 | 10,080 | 25.4% |
| Washington | 33,832 | 40,100 | 6,268 | 18.5% |
| West Virginia | 7,111 | 20,772 | 13,661 | 192.1% |
| Wisconsin | 8,508 | 24,411 | 15,903 | 186.9% |
| Wyoming | 2,589 | 2,319 | -270 | -10.4% |
| Totals | 1,211,323 | 1,876,564 | 665,241 | 54.9% |

## TABLE 7

## REPORTED CHILD ABUSE FATALITIES, 1986-1988[a]

| State | 1986 | 1987 | 1988 |
|---|---|---|---|
| Arkansas | N/A | 5 | 9 |
| California[b] | 27 | 83 | 96 |
| Colorado | 18 | 14 | 26 |
| District of Columbia | 2 | 5 | 9[c] |
| Hawaii | 1 | 2 | 2 |
| Idaho | 3 | 6 | 2 |
| Illinois | 79 | 54 | 97 |
| Indiana | 38 | 17 | 27 |
| Iowa | 9 | 7 | 9 |
| Kansas | 12 | 12 | 7 |
| Kentucky | 9 | 6 | 15 |
| Louisiana | 110 | 57 | 39 |
| Maine | 1 | 1 | 2 |
| Maryland | 17 | 23 | 21 |
| Massachusetts | 15 | 12 | 25 |
| Michigan | 15 | N/A | N/A |
| Minnesota | 10 | 5 | N/A |
| Mississippi | 7 | 20 | 10 |
| Missouri | 18 | 19 | 28 |
| Montana | 3 | 7 | 2 |
| Nebraska | 2 | 2 | 3 |
| Nevada | 4 | 7 | N/A |
| New Jersey | 12 | 26 | 24 |
| New Mexico | 7 | 11 | 8 |
| New York | 181 | 166 | 198 |

---

[a] Source: National Committee for the Prevention of Child Abuse, 1989. (Note: several deaths from 1988 are still under investigation)

[b] In 1987, California altered its method for recording child abuse fatalities.

[c] Estimate

## TABLE 7 (Cont'd)

| State | 1986 | 1987 | 1988 |
|---|---|---|---|
| North Carolina | 3 | 12 | 2 |
| North Dakota | N/A | N/A | 0 |
| Ohio | 50 | 75 | N/A |
| Oklahoma | 24 | 31 | 23 |
| Oregon | 18 | 23 | 14 |
| Pennsylvania | 44 | 44 | 40 |
| Rhode Island | 4 | 4 | 2 |
| South Carolina | 25 | 13 | 14 |
| South Dakota | 2 | 8 | 2 |
| Texas | 129 | 97 | 78[c] |
| Utah | 3 | 4 | 5 |
| Vermont | 1 | 2 | 0 |
| Virginia | 14 | 27 | 25 |
| Washington | 37 | 24 | 26[c] |
| Wisconsin | 15 | 23 | N/A |
| Wyoming | 3 | 0 | 4 |
| Total Projected Fatalities Nationwide | 1171 | 1163 | 1225 |
| Percentage Change 86-87 | | 0% | |
| Percentage Change 87-88 | | | +5% |

## TABLE 8

## FAMILIES AS A PERCENTAGE OF THE TOTAL HOMELESS POPULATION IN SELECTED CITIES, 1985-1988[a]

| CITY | 1985 | 1986 | 1987 | 1988 | %Chng |
|---|---|---|---|---|---|
| Boston | 40 | 21 | 20 | 26 | -35 |
| Chicago | 40 | 40 | 40 | 40 | 0 |
| Detroit | 20 | N/A | 40 | 55 | +175 |
| Los Angeles | N/A | N/A | 30 | 35 | +17 |
| Minneapolis | 15 | 5 | 16 | 18 | +20 |
| New Orleans | N/A | 10 | 20 | 15 | +50 |
| New York | 66 | 76 | 63 | 62 | -6 |
| Philadelphia | N/A | 50 | 33 | 33 | -34 |
| Phoenix | 20 | 20 | 25 | 20 | 0 |
| San Antonio | 4 | 10 | 30 | 33 | +725 |
| San Francisco | 15 | 20 | 20 | 15 | 0 |
| Seattle[b] | 28 | 35 | 30 | 37 | +32 |
| Washington, DC | 25 | N/A | 23 | N/A | -8 |
| Average % change in the total homeless population that is families: | | | | | +78% |

---

[a] Source: The United States Conference of Mayors, A Status Report on Hunger and Homelessness in America's Cities [1985, 1986, 1987, 1988], 1989.

[b] In Seattle, an additional 2.2% are childless couples.

## TABLE 9

## CHILDREN ENTERING FOSTER CARE BY AGE IN TEN MOST POPULOUS STATES, 1986-1988[a]

| State | | 1986 | 1987 | 1988 |
|---|---|---|---|---|
| California | 6 or under | 12,447 | 13,059 | 13,849 |
| | 7-12 | 6,701 | 6,786 | 6,226 |
| | 13-18 | 10,896 | 9,279 | 8,408 |

In 1985[b], California reported a total of 25,749 entering cases, 37% of whom were under age 6, 36% over age 12.

| | | | | |
|---|---|---|---|---|
| Florida | Under 6 | 1,396 | | |
| | 6-12 | 975 | | |
| | 13-18 | 1,083 | | |

In 1985, Florida reported a total of 3,251 entering cases, 40% of whom were under age 6, 32% over age 12.

| | | | | |
|---|---|---|---|---|
| Illinois | Under | 2,879 | | |
| | 6-12 | 2,119 | | |
| | 13-18 | 2,151 | | |
| | 19+ | 60 | | |

In 1985, Illinois reported a total of 6,936 entering cases, 45% of whom were under age 6, 25% over age 12.

| | | | | |
|---|---|---|---|---|
| Michigan | 6 or under | 1,980 | 2,939 | 3,075 |
| | 7-11 | 1,369 | 1,406 | 1,594 |
| | 12-18 | 2,434 | 1,337 | 1,412 |

In 1985, Michigan reported a total of 4,850 entering cases, 28% of whom were under age 6, 37% over age 12.

| | | | | |
|---|---|---|---|---|
| New Jersey*<br>*Children entering placement, including fc | Under 6 | 2,356 | 2,443 | 2,411 |
| | 6-12 | 2,724 | 2,722 | 2,768 |
| | 13-18 | 3,546 | 3,313 | 3,072 |
| | 19+ | 212 | 203 | 246 |

In 1985, New Jersey reported a total of 5,100 entering cases, 37% of whom were under age 6, 36% over age 12.

---

[a] Source 1986-1988 data: Select Committee on Children, Youth and Families 10-State Substitute Care Survey.

[b] Source 1985 data for all states: State Child Welfare Abstracts 1980-1985 prepared for DHHS, December 1987 (#153).

TABLE 9 (Cont'd)

| State | | 1986 | 1987 | 1988 |
|---|---|---|---|---|
| New York | Under 6 | 5,966 | 7,318 | |
| | 6-12 | 4,241 | 4,599 | |
| | 13-18 | 5,747 | 5,095 | |

In 1985, New York reported a total of 13,854 entering cases, 38% of whom were under age 6, 36% over age 12.

| | | | | |
|---|---|---|---|---|
| N. Carolina | Under 6 | 869 | 885 | 948 |
| | 6-12 | 700 | 761 | 716 |
| | 13-18 | 1,035 | 1,008 | 1,046 |

In 1985, North Carolina reported a total of 2,635 entering cases, 35% of whom were under age 6, 37% over age 12.

| | | | | |
|---|---|---|---|---|
| Ohio | Under 6 | 3,282 | | |
| | 6-12 | 2,210 | | |
| | 13-18 | 3,364 | | |
| | 18-21 | 4 | | |

In 1985, Ohio reported a total of 5,203 entering cases, 34% of whom were under age 6, 40% over age 12.

| | | | | |
|---|---|---|---|---|
| Pennsylvania*<br>*age of children in foster care | Under 5 | 2,322 | 2,444 | 3,021 |
| | 5-12 | 3,128 | 3,447 | 3,765 |
| | 12-18 | 6,889 | 7,099 | 7,308 |
| | 18+ | 846 | 761 | 703 |

In 1985, Pennsylvania reported a total of 12,901 entering cases, 21% of whom were under age 6, 50% over age 12.

| | | | | |
|---|---|---|---|---|
| Texas | Under 6 | 2,067 | | |
| | 6-12 | 1,417 | | |
| | 13-18 | 1,055 | | |

In 1985, Texas reported a total of 3,241 entering cases, 45% of whom were under age 6, 23% over age 12.

## TABLE 10

## CHILDREN ENTERING FOSTER CARE BY RACE/ETHNICITY IN TEN MOST POPULOUS STATES, 1986-1988[a]

| State | | 1986 | 1987 | 1988 |
|---|---|---|---|---|
| California | White | 13,654 | 13,472 | 13.238 |
| | Minority | 16,374 | 15,653 | 15,247 |
| | In 1985[b], 51% of children entering foster care in California were minority. | | | |
| Florida | White | 2,305 | 3,065 | 3,292 |
| | Minority | 1,127 | 1,731 | 2,019 |
| | In 1985, 31% of children entering foster care in Florida were minority. | | | |
| Illinois | White | 3,538 | | |
| | Minority | 3,661 | | |
| | In 1985, 50% of children entering foster care in Illinois were minority. | | | |
| Michigan | White | 2,798 | 2,727 | 2,919 |
| | Minority | 2,985 | 2,955 | 3,162 |
| | In 1985, 53% of children entering foster care in Michigan were minority. | | | |
| New Jersey | White | 2,825 | 2,578 | 2,454 |
| | Minority | 6,015 | 6,103 | 6,089 |
| | In 1985, 65% of children entering foster care in New Jersey were minority. | | | |

---

[a] Source 1986-1988 data: Select Committee on Children, Youth and Families 10-State Substitute Care Survey.

[b] Source 1985 data for all states: State Child Welfare Abstracts 1980-1985 prepared for DHHS, December 1987 (#153).

## TABLE 10 (Cont'd)

| State | | 1986 | 1987 | 1988 |
|---|---|---|---|---|
| New York | White | 4,520 | 4,528 | |
| | Minority | 11,434 | 12,484 | |

In 1985, 72% of children entering foster care in New York were minority.

| | | | | |
|---|---|---|---|---|
| N. Carolina | White | N/A | N/A | N/A |
| | Minority | N/A | N/A | N/A |
| Ohio | White | 6,021 | | |
| | Minority | 2,678 | | |

In 1985, 35% of children entering foster care in Ohio were minority.

| | | | | |
|---|---|---|---|---|
| Pennsylvania | White | N/A | N/A | N/A |
| | Minority | N/A | N/A | N/A |
| Texas | White | 2,365 | | |
| | Minority | 2,174 | | |

In 1985, 52% of childen entering foster care in Texas were minority.

## TABLE 11

## TRENDS AND PROJECTIONS IN PROGRAM FUNDING AND PARTICIPATION, 1981-1990

| | IV-B CHILD WELFARE SERV[a] | | IV-E FOSTER CARE[a] | | JUVENILE JUSTICE | |
|---|---|---|---|---|---|---|
| YEAR | # CHILDREN | FUNDING | # CHILDREN | FUNDING | #YOUTH IN JUV. FAC.[b] | JJDPA FUNDING[c] |
| 1981 | N/A[d] | 163.6 | 104,851 | 308.8 | N/A | 100.0 |
| 1982 | N/A | 156.3 | 97,309 | 373.8 | N/A | 70.0 |
| 1983 | N/A | 156.3 | 97,367 | 393.5 | 80,091 | 70.0 |
| 1984 | N/A | 165.0 | 102,051 | 445.2 | N/A | 70.2 |
| 1985 | N/A | 200.0 | 109,122 | 546.2 | 83,402 | 70.2 |
| 1986 | N/A | 198.1 | 110,586 | 647.1 | N/A | 67.3 |
| 1987 | N/A | 222.5 | 111,879 | 716.3 | 91,646 | 70.2 |
| 1988 | N/A | 239.4 | 122,949[e] | 891.0[e] | N/A | 66.7 |
| 1989 | N/A | 246.7 | 124,178[e] | 1022.6[e] | N/A | 66.7 |
| 1990 | N/A | 246.7 | N/A | 1154.2[e] | N/A | N/A |

---

[a] Source for Title IV-B and Title IV-E of the Social Security Act, 1981-1990, from Background Material and Data on Program within the Jurisdiction of the Committee on Ways and Means, U.S. House of Representatives, 1989.

[b] Youth in public and private juvenile facilities. Source: Children in Custody, 1975-85, U.S. DOJ, 1989.

[c] Appropriations under the Juvenile Justice and Delinquency Prevention Act of 1974.

[d] N/A: Not available or not applicable.

[e] Estimate

## TABLE 11 (CONTINUED)

## TRENDS AND PROJECTIONS IN PROGRAM FUNDING AND PARTICIPATION, 1981-1990

| | MENTAL HEALTH | | CAPTA[f] | | XX SOC. SERV.[g] (Child Welfare) | |
|---|---|---|---|---|---|---|
| YEAR | #CHILDREN | ADAMH FUNDING[h] | #CHILDREN | FUNDING | #CHILDREN | FUNDING |
| 1981 | N/A | 519.4 | N/A | 22.9 | N/A | N/A |
| 1982 | N/A | 428.1 | N/A | 16.2 | N/A | N/A |
| 1983 | N/A | 469.0 | N/A | 16.2 | N/A | N/A |
| 1984 | N/A | 462.0 | N/A | 16.2 | N/A | N/A |
| 1985 | N/A | 490.0 | N/A | 26.0 | N/A | N/A |
| 1986 | N/A | 469.0 | N/A | 24.8 | N/A | N/A |
| 1987 | N/A | 508.9 | N/A | 25.9 | N/A | N/A |
| 1988 | N/A | 487.3 | N/A | 24.8 | N/A | N/A |
| 1989 | N/A | 502.7 | N/A | 25.3 | N/A | N/A |
| 1990 | N/A | N/A | N/A | N/A | N/A | N/A |

---

[f] The Child Abuse Prevention and Treatment Act of 1974, as amended.

[g] Source for Title XX of the Social Security Act, 1981-1990, from Background Material and Data on Proram within the Jurisdiction of the Committee on Ways and Means, U.S. House of Representatives, 1989.

[h] Appropriations under the Alcohol, Drug Abuse and Mental Health Block Grant 1982-1989; 1981 funding represents combined funding for categorical programs before they were consolidated into the block grant in FY 1982. Funding for youth services is not detailed separately.

## TABLE 12

## TRENDS IN PROGRAM FUNDING 1981-1989[a]

(in 1981 constant dollars in millions)

| YEAR | TITLE IV-B CHILD WELFARE SERV. | TITLE IV-E FOSTER CARE[b] | JUVENILE JUSTICE | MENTAL HEALTH | CAPTA |
|---|---|---|---|---|---|
| 1981 | 163.6 | 308.8 | 100.0 | 519.4 | 22.9 |
| 1982 | 146.8 | 351.1 | 65.8 | 402.2 | 15.2 |
| 1983 | 140.6 | 354.0 | 63.0 | 421.9 | 14.6 |
| 1984 | 142.9 | 385.7 | 60.8 | 400.2 | 14.0 |
| 1985 | 167.7 | 458.1 | 58.9 | 411.0 | 21.8 |
| 1986 | 161.7 | 528.3 | 54.9 | 382.9 | 20.2 |
| 1987 | 175.0 | 563.4 | 55.2 | 400.3 | 20.4 |
| 1988 | 180.4 | 671.4 | 50.3 | 367.2 | 18.7 |
| 1989 | 178.8 | 741.1 | 48.3 | 364.3 | 18.3 |

---

[a] Conversion to constant dollars based on 1990 Budget Implicit Price Deflators for Composition of Total Outlays, Office of Management and Budget, January 1989. Base funding levels represent appropriations for federal fiscal year for all programs except Title IV-E Foster Care, for which funding levels represent federal payments for that year.

[b] Title IV-E constant dollar estimates should be viewed with caution as program funding may be claimed for up to 2 years after service year.

## TABLE 13

## TITLE IV-E FOSTER CARE EXPENDITURES, 1981-1988[a]
(in thousands of dollars)

| | Average # Children/ Month | Payments | Admin. | Training | Total |
|---|---|---|---|---|---|
| 1981 | 104,852 | 278,410 | 30,258 | 109 | 308,777 |
| 1982 | 98,309 | 301,241 | 72,076 | 532 | 373,849 |
| 1983 | 97,360 | 273,777 | 114,786 | 2,702 | 391,265 |
| 1984 | 102,049 | 301,591 | 156,542 | 5,813 | 463,946 |
| 1985 | 108,104 | 354,471 | 169,053 | 8,011 | 545,768 |
| 1986 | 110,586 | 396,127 | 207,104 | 9,550 | 647,055 |
| 1987 | 111,879 | 429,461 | 246,857 | 13,996 | 716,277 |
| 1988 | 122,949 | 519,259 | 340,332 | 29,985 | 891,065 |

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[a] Source: Background Material and Data on Programs within the Jurisdiction of the Committee on Ways and Means, 1989

# APPENDIX II

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# APPENDIX III

# CHILDREN IN SUBSTITUTE CARE SURVEY INSTRUMENT

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## HOUSE SELECT COMMITTEE ON CHILDREN, YOUTH AND FAMILIES SUBSTITUTE CARE SURVEY[1]

State:________________

Reporting Period:
SFY__ FFY__ CY__

| | 1986 | 1987 | 1988 |
|---|---|---|---|
| 1. # of children in fc on 1st day of reporting period | | | |
| 2. # of new entrants during year Total | | | |
| By age/race: a. under 6 | | | |
| b. 6-12 | | | |
| c. 13-18 | | | |
| d. by race/ethnicity | | | |
| 3. # of Reentries (out of total entrants) | | | |
| 4. Exiting during year<br>a. Total # exiting | | | |
| b. Length of stay 0-6 months | | | |
| 6-12 months | | | |
| 1-2 years | | | |
| 2+ yrs. | | | |

Respondent ________________

Title ________________

Phone (__) ________________

Address ________________

Date ________________

---

[1] Same definitions used as in Voluntary Cooperative Information System.

| | 1986 | 1987 | 1988 |
|---|---|---|---|
| c. Outcome: i. Reunification | | | |
| ii. Adoption | | | |
| iii. Emancipation | | | |
| iv. Other | | | |
| 5. Number of children in fc at end of reporting period<br>Total | | | |
| Length of Stay<br>0-6 months | | | |
| 6-12 months | | | |
| 1-2 years | | | |
| 2+ years | | | |
| 6. Number of children whose parents' parental rights have been terminated awaiting placement in adoptive homes | | | |

# SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES 10-STATE SURVEY ON SUBSTITUTE CARE

The most recently published national data on children in substitute care were for 1985 and were reported by the U.S. Department of Health and Human Services in December 1987. In order to obtain more recent estimates of the numbers of children in care, a telephone survey of the ten most populous states was conducted. The states were: California, Florida, Illinois, Michigan, New Jersey, New York, North Carolina, Ohio, Pennsylvania and Texas.

The survey sought available state data through 1988 on the total number of children in care, with disaggregation by age, race/ethnicity, time spent in care, re-entry into care, and outcome. The attached survey form presents the areas of inquiry. Respondents were told to use the same definitions as employed in submitting information as part of the Voluntary Cooperative Information System operated by the American Public Welfare Association. Contact persons were those individuals in state agencies who are responsible for the collection, analysis and/or reporting of these data. A listing of respondents who provided and verified data is provided at the end of this section.

## STATE CONTACT PERSONS RESPONDING TO TEN-STATE SURVEY ON SUBSTITUTE CARE

CALIFORNIA
Raymond Bacon, Analyst
Statistical Services Section
California Department of Social Services
Sacramento, CA

FLORIDA
Lisa Leverrier, Management Analyst II
Data Analysis Unit
Children, Youth and Families Program Office
State of Florida
Department of Health and Rehabilitation Services
Tallahassee, FL

ILLINOIS
Barry Colvin, Chief
Office of Planning, Monitoring and Evaluation
Illinois Department of Children and Family Services
Springfield, IL

MICHIGAN
James P. Evans, Unit Chief
Information Systems
Planning Division
Bureau of Planning and Fiscal Oversight
Office of Children and Youth Services
Lansing, MI 48909

NEW JERSEY
James Sansotera, Administrative Analyst
New Jersey Division of Youth and Family Services
Trenton, NJ

| | |
|---|---|
| NEW YORK | Lloyd Bishop<br>Federal Legislative Liaison<br>New York State Department of Social Services<br>Albany, NY |
| N. CAROLINA | Jacqueline Paris, Head<br>Systems Support Branch<br>Department of Human Resources<br>Division of Social Services<br>Raleigh, NC |
| OHIO | Douglas R. Oxenford, Data Coordinator<br>Department of Human Services<br>Division of Family and Children's Services<br>Ohio Department of Human Services<br>Columbus, OH |
| PENNSYLVANIA | Lawrence G. Woods, Director<br>Information Systems<br>Office of Children, Youth and Families<br>Harrisburg, PA |
| TEXAS | Dolores L. Torres, Systems/Data Analyst<br>Texas Department of Human Services<br>Austin, TX |

# APPENDIX IV

# FEDERAL PROGRAMS AFFECTING CHILDREN IN STATE CARE

## SOCIAL SERVICES BLOCK GRANT

### Authorization

Title XX of the Social Security Act; permanently authorized.

### Program Description

Social Services Block Grants (SSBG) are provided to States for activities determined appropriate social services by the State. Typical activities include child day care, protective services for children and adults, and home care services for the elderly and handicapped. This program is administered by the Office of Human Development Services in the Department of Health and Human Services (DHHS).

### Funding

Funds are allocated from the Federal Government to the States, according to their relative population size. No matching funds are required.

### Funding Amounts (Appropriations)[1]

FY 1981: $3.0 billion [2]
FY 1984: $2.7 billion
FY 1986: $2.6 billion
FY 1987: $2.7 billion

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[1] Indicates total program spending. Portion spent on children and youth not available.

[2] Spending for social services, child day care and training under Title XX, before 1981 amendements consolidated activities into a block grant.

FY 1988: $2.7 billion
FY 1989: $2.7 billion

Participation Data are unavailable.

## CHILD WELFARE

### Authorization

Title IV-B of the Social Security Act; permanently authorized.

### Program Descriptions

Title IV-B of the Social Security Act authorizes three activities relating to child welfare: child welfare services; child welfare training; and child welfare research and demonstration projects. All are administered by the Administration for Children, Youth, and Families, DHHS. The following describes each of these programs:

Child Welfare Services: The child welfare services program authorizes Federal matching funds for the provision of child welfare services to children and their families, without Federal income eligibility requirements. Eligible services include those intended to protect the welfare of children; help prevent or solve problems that may result in the neglect, abuse, exploitation or delinquency of children; help prevent the separation of children from their families and help return children who have been removed to their families; and provide for the care of children who cannot be returned home. Because of minimal reporting requirements, there are not comprehensive data on the specific services provided by States under this program. According to DHHS estimates, however, the majority of child welfare services funds (Federal and State combined) is spent on foster care services. Other services provided include counseling and rehabilitation; adoption subsidies and services; and child protection services.

Child Welfare Training: The child welfare training program authorizes funding for awards to institutions of higher education, usually social work schools, for student assistance and curriculum development in the child welfare area. The program also funds various regional training institutes, technical assistance projects, and in-service training programs to help States administer Federal child welfare programs.

Child Welfare Research and Demonstration: The child welfare research and demonstration program awards grants to universities, public agencies, and private nonprofit organizations for projects in the child welfare area. Program priorities include broad areas such as helping to improve agency efficiency and program evaluation, and specific projects to help particular groups, such as abused children, disadvantaged unemployed youth, and children and youth in foster care. This program also funds resource centers that provide assistance to States and organizations in the area of child welfare.

## Funding

Under law, the child welfare services program is a 75% Federal matching program for the costs incurred by State, district, county, or other local child welfare services, including the costs of administering the child welfare services plan. In practice, however, States spend considerably more than the required 25% match for child welfare services. The funds are allocated to State public welfare agencies on the basis of the State's population under age 21 and per capita income. There are no Federal requirements regarding distribution of the funds within the State.

Both the child welfare training and the child welfare research and demonstration programs are 100% federally funded. Funding may be made in the form of grants, contracts, or cooperative arrangements; and may be made in advance or as reimbursement.

Funding Amounts (Appropriations in millions)

| | Child Welfare Services | Child Welfare Training | Child Welfare Research and Development |
|---|---|---|---|
| FY 1981 | $163.5 | $5.2 | $11.2 |
| FY 1982 | 156.3 | 3.8 | 10.6 |
| FY 1983 | 156.3 | 3.8 | 10.6 |
| FY 1984 | 165.0 | 3.8 | 10.0 |
| FY 1985 | 200.0 | 3.8 | 12.0 |
| FY 1986 | 198.0 | 3.7 | 11.3 |
| FY 1987 | 222.0 | 3.8 | 11.3 |
| FY 1988 | 239.4 | 3.7 | 10.9[1] |
| FY 1989 | 246.7 | 3.7 | 11.0 |

Participation Data

Because of minimal reporting requirements for the child welfare services program, there are no reliable data on the number of children served. During the 1970s, an estimated 200,000 to 300,000 children annually received services funded by the Federal-State child welfare services program.

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[1] According to the Office of Human Development Services (OHDS) FY 1989 budget justifications, $2.4 million of that was to be reprogrammed for general social services research.

## FOSTER CARE AND INDEPENDENT LIVING

### Authorization

Title IV-E of the Social Security Act. The foster care program is permanently authorized; the independent living program is authorized through FY 1989.

### Program Descriptions:

Foster Care: The foster care program is an entitlement program that provides Federal matching funds to States for maintenance payments made for AFDC-eligible children in foster care. The program is required of States participating in the AFDC program (all States do). The maintenance payments are to be used for the cost of (and the cost of providing) food, shelter, clothing, daily supervision, school supplies, personal incidentals, liability insurance for the child, and reasonable travel to the child's home for visits. Children receiving IV-E foster care payments are deemed eligible for Medicaid and the State where the child resides is responsible for providing the Medicaid coverage. The foster care program is structured to provide incentives to States to implement programs and procedures to help families remain intact and limit the need for foster care, including linkages with the child welfare services program under Title IV-B. The foster care program is administered by the Administration for Children, Youth, and Families (ACYF), DHHS.

Independent Living: Under the foster care program, payments generally end when the child reaches age 18, although some States continue aid to high school students under age 19. In 1986, a new State entitlement program was established to help States provide services to facilitate the transition of children age 16 and over from foster care to independent living. Services that States may provide include those that would enable participants to seek a high school diploma or its equivalent or to take vocational training; to provide training in daily living skills; to provide for counseling; to coordinate otherwise available services; to provide for the establishment of outreach programs; and/or to provide each participant with a written plan for transitional independent living to be incorporated into the participant's case plan. The independent living program is administered by ACYF, DHHS.

## Funding

Foster Care: The Federal match for a given State's foster care expenditure is based on the State's Medicaid matching rate, which averages about 53% nationally. States have up to 2 years to claim expenditures made for foster care maintenance payments. Foster care funding is linked to funding for the child welfare services program under Title IV-B. If the appropriations for the child welfare services program reach specified levels, each State's expenditures for foster care maintenance are limited to a ceiling amount calculated based on adjusted foster care funding in prior years or the State's under age 18 population. Within this ceiling amount, States may transfer unused foster care funds to child welfare services, with certain limitations. If the mandatory ceiling is not in effect, States are allowed to transfer certain foster care funds within the ceiling amount for use for child welfare services if they implement certain services and procedures intended to protect children in foster care.

Independent Living: Under the independent living program, each State is to receive a share of $45 million in each of FY 1987, FY 1988 and FY 1989 based on its FY 1984 AFDC foster care caseload. Unused funds are to be allocated to one or more States on the basis of relative need.

## Funding Amounts[1,3]

### Foster Care

FY 1981: $308.8 million
FY 1982: $373.8 million
FY 1983: $393.5 million
FY 1984: $445.2 million
FY 1985: $546.2 million
FY 1986: $647.1 million
FY 1987: $716.3 million
FY 1988: $891.0 million (estimate)
FY 1989: $1,022.6 million (estimate)

### Independent Living

FY 1987: $45 million
FY 1988: $45 million
FY 1989: $45 million

## Program Participation[2,3]

### Foster Care:

FY 1981: 104,851
FY 1982: 97,309
FY 1983: 97,367
FY 1984: 102,051
FY 1985: 109,122
FY 1986: 110,586
FY 1987: 111,879
FY 1988: 122,949 (estimate)

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[1] States have up to two years to submit claims for foster care expenditures, consequently, figures are subject to change.

[2] States have up to two years to submit claims for foster care expenditures, thus participation data are subject to change.

[3] Source: Background Material and Data on Programs within the Jurisdiction of the Committee on Ways and Means, U.S. House of Representatives, 1989.

FY 1989: 124,178 (estimate)

Independent Living:
Not available.

## ADOPTION ASSISTANCE

### Authorization

Title IV-E of the Social Security Act; permanently authorized.

### Program Description

The adoption assistance program is an entitlement program required of States participating in AFDC (all States do). Under this program, States provide adoption assistance payments to parents who adopt Supplemental Security Income (SSI)- or AFDC- eligible children with "special needs." States may claim Federal matching funds for these payments. Amendments in 1986 eliminated the former itemized tax deduction for adoption expenses to provide that Federal matching funds may also be claimed under the adoption assistance program for adoption expenditures made after December 31, 1986, for a child with special needs placed for adoption in accordance with applicable State and local laws. A child with special needs is defined as one with a specific condition or situation, such as ethnic background, age, membership in a sibling group, or mental or physical handicap, which prevents placement without assistance payments. Before designating a child as having special needs, the State must determine that he cannot or should not be returned to his family and that reasonable efforts have been made to place the child without providing assistance. Adoption assistance is available only after the child is placed for adoption and an interlocutory (provisional) decree of adoption is issued or the adoption is finalized. Children for whom an adoption agreement is in effect and who have been placed for adoption in accord with applicable State and local laws are deemed eligible for Medicaid in the State where the child resides, whether or not adoption assistance payments are being made. The adoption assistance program is administered by ACYF, DHHS.

## Funding

States are entitled to claim Federal matching funds for adoption assistance payments made, based on the State's Medicaid matching rate (which averages about 53% nationally). Adoption assistance payments are made to the parents in accordance with an adoption assistance agreement developed between the parents and the State agency. The agreement stipulates the amount of the payments to be made and additional services or assistance to be provided. The payment amounts are determined on the basis of the adoptive parents' circumstances and the needs of the child, but cannot exceed the amount the child would receive for maintenance in a foster family home under the Title IV-E foster care program. The payment amounts may be adjusted based on changed circumstances. The payments may continue until the child is 18; if the child is mentally or physically handicapped, payments may continue until age 21, at State option.

Effective January, 1987, States can claim 50% federal matching funds for non-recurring adoption costs (e.g. court costs, adoption agency fees, other legal fees).

## Funding Amounts[1]

FY 1981: $ 0.5 million (expended, six States participated)
FY 1984: $ 26.7 million (expended)
FY 1986: $ 41.4 million (appropriated)
FY 1987: $ 98.1 million (est. expenditures)
FY 1988: $108.0 million (est. expenditures)
FY 1989: $133.9 million (est. expenditures)

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[1] States have up to two years to claim reimbursement for adoption assistance espenditures, thus expenditure data are subject to change.

Participation Data[1]

FY 1984: 11,000 average monthly
FY 1986: 21,000 average monthly
FY 1988: Nearly 36,000 children were served
FY 1989: An estimated 43,000 children will be served

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[1] States have up to two years to clain reimbursement for adoption assistance expenditures, thus participation data are subject to change.

## ADOPTION OPPORTUNITIES

### Authorization

Title II of the Child Abuse Prevention and Treatment Act; as amended authorized through FY 1991.

### Program Description

The adoption opportunities program sponsors various projects to facilitate and encourage the adoption of children with special needs, that is, children who are considered hard to place for adoption due to race, age, or handicap. Projects supported by this program include a national adoption information exchange to link prospective adoptive parents with children who are free for adoption; technical assistance to States and many local and private agencies in improving adoption practices; and information to groups and individuals who are interested in adopting special needs children. In FY 1988, under P.L. 100-294, three new programs were added: 1) grants which place special emphasis on recruitment of minority adoptive families; 2) post-legal adoption services (e.g. individual and family counseling case request) for families which have adopted special needs children; 3) grants to increase the placement of foster children.

### Funding

One hundred percent Federal funding is provided for demonstration projects to State and local government agencies or public and private nonprofit agencies.

The new minority adoptive families recruitment program and the post-legal adoption services program for families which adopt special needs children are each authorized at $3 million in FY 1989 and such sums as necessary through FY 1991; the third new program, grants to increase the placement of foster children, is not to exceed $1 million in any fiscal year. All three programs are not authorized to receive funding unless appropriations under Title II exceed $5 million.

## Funding Amounts (Appropriations)

FY 1981: $5.0 million
FY 1984: $1.9 million
FY 1986: $4.8 million
FY 1987: $5.0 million
FY 1988: $4.8 million
FY 1889: $6.0 million

## Participation Data

Not available.

## CHILD ABUSE GRANTS

### Authorization

Child Abuse Prevention and Treatment Act; authorized through FY 1991, except the Children's Justice and Assistance Act, which is authorized through FY 1994.

### Program Description

The Child Abuse Prevention and Treatment Act, as amended, authorizes three State grant programs and one discretionary grant program relating to the prevention and treatment of child abuse and neglect. It also establishes the National Center on Child Abuse and Neglect which, among other things, administers these programs and provides for the collection and dissemination of information on child abuse and neglect. Grants to address family violence are also authorized under the Child Abuse Act and are discussed in another section of this report. The child abuse programs are all administered by ACYF, DHHS.

One child abuse State grant program authorizes funds for activities to prevent or treat child abuse. To be eligible for these funds, States must meet certain criteria, including establishing provisions for reporting and investigating known and suspected instances of child abuse and neglect and protecting the welfare of involved children. Funds are typically used as seed money for innovative projects. In 1988, P.L. 100-294 mandated that particular emphasis be placed on projects involving the early identification and prevention of child abuse.

A second State grant program provides funds to States to develop and operate programs for responding to reports of medical neglect of disabled infants with life-threatening conditions. The implementation of such programs is required for receipt of funds under the other two State grant programs.

A third State grant program, established in 1986 and amended in 1988, assists States in the development, establishment, and operation of programs to improve the handling, investigation, and prosecution of child abuse cases, especially those involving child sexual abuse. To be eligible for this program, which is administered in cooperation with the U.S. Attorney General, States must meet specified eligibility criteria; and they must establish and act upon the recommendations of a task force on children's justice regarding changes to be made in the handling of child abuse cases in specified categories.

The child abuse discretionary grants program provides Federal funding for research and demonstration projects aimed at preventing, detecting, and treating child abuse and at service improvement projects.

P.L. 100-294 established a new Presidential Commission on Child and Youth Deaths to examine the causes and possible remedies for child deaths associated with abuse, neglect, poor health care, sudden infant death syndrome, accidents and suicide.

## Funding

There are no Federal matching requirements for the child abuse and neglect grants authorized under the Child Abuse Act. The funding amounts for the State grant program for preventing and treating child abuse are based on each State's under-18 population. At least $9 million of the funds appropriated for the Child Abuse Act annually is to be made available for the State grant program. Up to $5 million annually is authorized under the Child Abuse Act for the additional State grants to help States develop and operate programs for responding to reports of medical neglect. Four and a half percent of the funds collected in the Crime Victims Fund under the Victims of Crime Act, up to $10 million annually, is to be made available for the State grants for improving the handling of child abuse cases (Children's Justice and Assistance grants). As amended in 1988, States must now provide 15% of CJA grants to Native Americans. At least $11 million annually of funds appropriated for the Child Abuse Act is to be used for research and demonstration projects. In addition, up to $5 million annually is to be used for research and demonstration relating to the identification, treatment and prevention of child sexual abuse.

Funding Amounts (Appropriations)

FY 1981: $22.9 million
FY 1982: $16.2 million
FY 1983: $16.2 million
FY 1984: $16.2 million
FY 1985: $26.0 million
FY 1986: $24.8 million
FY 1987: $25.9 million
FY 1988: $24.8 million
FY 1989: $25.3 million

(Includes funds for State grants for prevention and treatment, medical neglect grants [which did not begin until FY 1985], and discretionary grants. Does not include funds for State grant program for improved procedures for handling child abuse cases, which began in FY 1986, listed below.)

Funding amounts -- Children's Justice and Assistance Act

FY 1981: Not applicable (program began in FY 1987)
FY 1984: Not applicable
FY 1986: Not applicable
FY 1987: $2.8 million
FY 1988: $3.4 million
FY 1989: $3.6 million

Participation Data: Not applicable.

## CHILD ABUSE CHALLENGE GRANTS

### Authorization

Originally, FY 1985 Continuing Appropriations (P.L. 98-473); Transferred in 1989 to the Child Abuse Prevention and Treatment Act, as amended and authorized through FY 1991.

### Program Description

The child abuse challenge grant program was established to encourage States to develop and maintain trust funds or other funding mechanisms to support child abuse and neglect activities, including 1) Statewide educational and informational seminars to enhance public awareness of the problems of child abuse and neglect; 2) community-based programs in parenting, prenatal care, child development, child care, sexual abuse prevention, and self-care training for latchkey children; and 3) community-based programs in child abuse counseling, peer support groups for abusive or potentially abuse parents, lay health visitors, and repite or crisis child care. The program is administered at the Federal level by the ACYF, DHHS; at the State level, the program is administered by the State's trust fund advisory board or, if none exists, the State liaison agency to the National Center on Child Abuse and Neglect.

### Funding

Each eligible State's annual grant amount is to be based on the lesser of 25% of the amount made available by the State for child abuse activities the previous fiscal year or the number of children residing in the State multiplied by fifty cents. Authorized at "such sums as necessary" through FY 1991.

FY 1981: Not applicable (program began in FY 1985)
FY 1984: Not applicable

| | |
|---|---|
| FY 1986: | Approximately $5 million |
| FY 1987: | Approximately $5 million |
| FY 1988: | $4.78 million |
| FY 1989: | $4.83 million |

Participation Data

Funds under this program were first distributed in FY 1986 (from FY 1985 appropriations). Children's Trust Funds, the principal recipients of the challenge grants, have been established in 47 States (all except Colorodo, Mississippi and Wyoming).

# TEMPORARY CHILD CARE FOR HANDICAPPED CHILDREN AND CRISIS NURSERIES ACT OF 1986

## Authorization

Temporary Child Care for Handicapped Children and Crisis Nurseries Act of 1986, as amended; authorized through FY 1991.

## Program Description

Supports respite care for handicapped children and crisis nurseries for children at risk of abuse or neglect. In FY 1988, 16 grants were awarded for each program.

## Funding Amounts (Appropriations)

FY 1988: $4.8 million
FY 1989: $4.9 million

## FAMILY VIOLENCE PROGRAMS

### Authorization

Title III of the Child Abuse Prevention and Treatment Act of 1974, as amended; and the Victims of Crime Act of 1984, as amended. Programs under the Child Abuse Act authorized through FY 1991; programs under the Victims of Crime Act authorized through FY 1994.

### Program Descriptions

Family Violence Programs Under the Child Abuse Act: Title III of the Child Abuse Act, as amended, authorizes a program of demonstration grants for States and Indian tribes for activities relating to the prevention and treatment of family violence; mandates the establishment of a national clearinghouse on family violence prevention; and authorizes funds for law enforcement training and technical assistance grants.

The family violence demonstration grant program authorizes grants for States and Indian tribes for activities intended to prevent family violence and to provide immediate shelter and related assistance to victims and their dependences.

The National Clearinghouse on Family Violence prevention is mandated to collect, prepare, analyze and disseminate information, statistics, and analyses on the incidence, prevention, and assistance to victims of family violence. The activities of the Clearinghouse are to be coordinated with those of the National Center on Child Abuse and Neglect.

The law enforcement training and technical assistance grants are for regionally based training and technical assistance for personnel of local and State law enforcement agencies with means to respond to incidents of family violence. Priority is given to projects that propose to develop, demonstrate, or diseminate information on improved techniques for responding to family violence incidents. As amended by P.L. 100-294, law enforcement agencies must work with domestic violence shelters, social service agencies and hospitals in developing and providing training programs.

Also established by P.L. 100-294 is the "Family Member Abuse Information and Documentation Project" which is intended to develop data on characteristics of family violence and to provide for objective documentation on victims of family violence and their dependents.

Family Violence Programs Under the Victims of Crime Act, as Amended: The Victims of Crime Act, as amended, authorizes a crime victims fund to consist of fines collected from persons convicted of certain Federal offenses. Up to $110 million collected in this fund is to be used for awards to crime victim compensation programs; for crime victim assistance programs; and for State grants for improving the handling of child abuse cases (described in another section of this report).

Grants under the crime victims compensation program are awarded to States operating programs to compensate victims of crime or their survivors for medical expenses, wage loss, and funeral expenses attributable to a crime and to provide certain other services. Under the Victims of Crime Act, as amended in 1988, States are required to compensate victims of domestic violence and are prohibited from denying compensation on the basis of the victim's cohabitation or familial relationship with the offender.

Crime victim assistance grants are given to programs for providing services for victims of crime, including crisis intervention services; temporary shelter; support services; court-related services; and payment for forensic medical exams. Priority for awards is to be given to programs providing assistance to victims of sexual assault, spouse abuse, or child abuse.

The family violence programs under the Child Abuse Act are administered by the Office of Human Development Services, DHHS, except the law enforcement training and technical assistance grants, which are administered by the Office of Justice Programs, Department of Justice (DOJ). The family violence programs under the Victims of Crime Act are also administered by the Office of Justice Programs, DOJ. The following describes these programs.

## Funding

Child Abuse Act: Under the family violence demonstration grant program, each State is allotted an amount based on its population compared to the population in all the States. However, each State is to receive at least the greater of one-half of 1% of the amount available or $50,000. Local grantees (those funded by the States) are required to provide a 35% match the first year, 55% the second year, and 65% the third year. Funding to local grantees is limited to $50,000 per year for up to 3 years. Eighty-five percent of the amount appropriated is to be used for the family violence demonstration grant programs.

Up to $2 million annually of funds appropriated for family violence activities under Child Abuse Act is to be transferred to the Attorney General for law enforcement training and technical assistance grants. The grants are to be awarded competitively to law enforcement agencies with demonstrated effectiveness in preparing law enforcement personnel for handling family violence and priority is to go to agencies proposing to develop demonstrated or disseminate information on improved techniques for law enforcement officers to respond to family violence.

Victims of Crime Act: Under the crime victim compensation program, State compensation programs are to be awarded annually an amount equal to 35% of the amount paid by the program from State funds the previous fiscal year for compensation for victims of crime. (If States don't use their own funds for such a program, they can not receive funds under this program.) If there are not sufficient funds to award States this amount, the percentage is to be reduced. Of the first $100 million in the crime victims fund, 49.5% is to be made available annually for these grants.

Forty-five percent of the first $100 million deposited in the crime victims funds is to be made available annually for crime victim assistance programs. In addition, anything in excess of $105.5 million (up to $110 million) in the fund is to be used for crime victim assistance program grants; and funds earnmarked but not used for crime victim compensation grants or the grants under the Child Abuse Act for programs to improve the handling of child abuse cases are to be used for the crime victim assistance grants. Under the crime victims assistance program, each State is to receive $100,000 annually plus a proportion of any remaining available money in the crime victims fund based on the State's proportion of the U.S. population.

Funding Amounts

| | Activities under Child Abuse Act | Crime Victims Fund |
|---|---|---|
| FY 1981: | Not applicable (program began in FY 85) | Not applicable (program began in FY 85) |
| FY 1986(est.): | $2.4 million | $60 million |
| FY 1987: | $8.5 million | $77.4 million |
| FY 1988: | $8.138 million | $93.6 million |
| FY 1989: | $8.219 million | |

Participation Data

Data are not yet available on either the participants in the family violence programs under the Child Abuse Act nor on the children served by the programs under the Victims of Crime Act.

## RUNAWAY YOUTH PROGRAM

### Authorization

Runaway and Homeless Youth Act, as amended, (Title III of the Juvenile Justice and Delinquency Prevention Act), authorized through FY 1992.

### Program Description

The runaway youth program funds local facilities providing temporary residential care and counseling and a national toll-free hotline for runaway and homeless youth and their families. The program is designed to meet the needs of these youth outside the law enforcement structure and the juvenile justice system. P.L. 100-690 authorized a new transitional living program to assist homeless youth ages 16 to 21 prepare for independent living. The law does not specify age or other eligibility criteria for the program; the regulations define "youth" as a person under the age of 18. Funds may also be used for acquisition and renovation of existing structures, provision of counseling services, staff training, and operating costs. The runaway youth program is administered by DHHS.

### Funding

Grants are made directly to the recipient shelter, but funds are allocated by State according to each State's under-18 population. The Federal share is 90%. The transitional living program is authorized at $5 million for Fy 1989 and such sums as necessary through FY 1992; however, the basic RHYA appropriation must exceed $26.9 million for it to receive funding.

### Funding amounts - RHYA (appropriations)

| | |
|---|---|
| FY 1981: | $11.0 million |
| FY 1984: | $23.3 million |
| FY 1986: | $23.3 million |
| FY 1987: | $23.3 million |
| FY 1988: | $26.1 million |
| FY 1989: | $26.9 million |

### Transitional Living Program

| | |
|---|---|
| FY 1989: | Not funded. |

## JUVENILE JUSTICE PROGRAM

### Authorization

Juvenile Justice and Delinquency Prevention Act of 1974, as amended; authorized through FY 1992.

### Program Description

The Juvenile Justice and Delinquency Prevention Act is designed to develop programs aimed at the prevention and treatment of delinquency among youth. The Act establishes a program of State formula grants and special emphasis programs for a number of activities. These include: community-based alternatives to incarceration, restitution sentences, programs to strengthen the family, diversion, and programs concerned with the special education needs of delinquent children. The Act also requires that status offenders not be placed in secure facilities and that juveniles in correctional institutions must be held separately from adults. In 1988, (under P.L. 100-690), a new program aimed at juvenile gang prevention and treatment was established and authorized at $10 million. This program is administered by the Office of Juvenile Justice and Delinquency Prevention (OJJDP), DOJ.

### Funding

Juvenile Justice and Delinquency Prevention: Grants are awarded to States local governments to assist in planning, establishing, operating, coordinating, and evaluating projects directly or through grants and contracts with public and private agencies. Funds are allocated annually among the States on the basis of relative population of people under age 18, with no State receiving less than $225,000.

## Funding Amounts (Appropriations)

| | |
|---|---|
| FY 1981: | $100.0 million |
| FY 1982: | $ 70.0 million |
| FY 1983: | $ 70.0 million |
| FY 1984: | $ 70.2 million |
| FY 1985: | $ 70.2 million |
| FY 1986: | $ 67.3 million |
| FY 1987: | $ 70.2 million |
| FY 1988: | $ 66.7 million |
| FY 1989: | $ 66.7 million |

## Participation Data

Not available.

# ABANDONED INFANTS ASSISTANCE ACT (P.L. 100-505)

Authorizes $10 million in FY 1989, $12 million in FY 1990 and $15 million in FY 1991 for demonstration projects for the family support, foster care, and residential care of infants and young children who have been abandoned in hospitals, particularly those children with acquired immune deficiency syndrome (AIDS). The Act also calls for studies to identify cost effective programs that provide assistance to infants and young children with AIDS, and to estimate the cost of such programs.

## ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH BLOCK GRANT

### Authorization

Title XIX, Part B of the Public Health Service Act, as amended; authorized through FY 1991.

The Alcohol, Drug Abuse, and Mental Health Services (ADMS) Block Grant authorizes (1) grants to States for prevention, treatment, and rehabilitation programs and activities to address alcohol and drug abuse, including demonstration programs targeted at high risk youth; and (2) grants to community mental health centers for the provision of mental health services, including the chronically mentally ill, severely emotionally disturbed children and adolescents, mentally ill elderly individuals, and other underserved populations. It also supports service research on community-based alcohol and drug abuse and mental health treatment programs.

In 1988, P.L. 100-690 mandated that at least 10% of the mental health share of the ADMS block grant be set aside for community-based mental health services for seriously emotionally disturbed children and youth.

This legislation also authorized programs and services designed to prevent and treat substance abuse among women, particularly pregnant women and post-partum women and their infants. In addition, additional resources were authorized to reduce waiting periods for substance abuse treatment and to assist intravenous drug abusers.

### Funding

Under P.L. 100-690, 68% is earmarked for alcohol and drug abuse activities, while 32% of the ADMS block grant is earmarked for mental health activities. States must distribute their services according to a new formula. Of funds received by the State for alcohol and drug abuse activities, at least 35% must be used for alcoholism and alcohol abuse services, at least 35% must be used for drug abuse services, and at least 20% must be used for prevention and early identification programs. Of funds received by the State for mental health services, at least 55% must be used for new programs, and at least 10% must be used for services for seriously emotionally disturbed children and youth.

## Funding Amounts (Appropriations)

FY 1981: $519 million (this figure represents combined funding for categorical programs before they were consolidated into the block grant in FY 1982)

FY 1982: $428 million
FY 1983: $469 million
FY 1984: $462 million
FY 1985: $490 million
FY 1986: $469 million
FY 1987: $508.9 million
FY 1988: $487.3 million
FY 1989: $502.7 million

## Participation Data

Not available.

# APPENDIX V

## STATE-BY-STATE LITIGATION ON BEHALF OF CHILDREN IN STATE CARE

# STATE-BY-STATE LITIGATION ON BEHALF OF CHILDREN IN STATE CARE

In the last decade, extensive litigation raising a range of issues within and across the systems of child welfare, juvenile justice, and mental health has been brought on behalf of children in state care. More than 80 cases have been brought in 20 states during that period, and growing concerns about the welfare of children in state care have resulted in an increasing amount of legal action in recent years. A significant number of these cases sought damages for children who were injured or mistreated while in state care.

Almost all of the cases have been settled in favor of the children. In many instances, because the alleged violations affected large numbers of children in the care of the state, such cases were brought as class action lawsuits. A significant number of these class action cases were settled by consent decrees, in which the government agreed to cease the activities asserted as illegal by those who brought the complaint. Such agreements require the approval of the court, and involve ongoing court monitoring. The remaining cases have been decided by the courts.

The following is a state-by-state listing of the relevant litigation within each major issue area.

Cases marked "C" denote those brought on behalf of children in the child welfare system. The claims raised in these cases include violations of the Due Process Clause and P.L. 96-272, The Adoption Assistance and Child Welfare Act of 1980, including the failure to make "reasonable efforts" to prevent family dissolution, provide preventive and reunification services to children and their families, such as housing and needed emergency assistance, and a lack of appropriate services and placements to address the needs of children in care; parent and social worker visitation, the criteria used to place children in foster and adoptive homes, and injuries to children while in state care.

Cases marked "J" denote those brought on behalf of children in the juvenile justice system who have been placed in adult jails, juvenile detention centers, training schools, and secure residential facilities. These cases include challenges to the placement of children in these facilities, the incarceration of children in adult jails, the co-mingling of status offenders with juvenile delinquents and/or adult offenders, and the conditions under which children were confined in these facilities. These conditions include overcrowding, inappropriate placement, unsanitary and dangerous physical conditions, lack of security, lack of adequate staff, abusive punishment including isolation, and lack of appropriate education and programming, and medical treatment. Alleged violations included the children's Fourteenth Amendment's Due Process Clause, the Eight Amendment's prohibition against "cruel and unusual" punishment, the Sixth Amendment's right to counsel, and the federal civil rights laws.

Cases marked "M" denote cases brought on behalf of children failing to receive appropriate mental health services. Many of these children were already in either the child welfare or juvenile justice systems when these claims were raised. Claims involved allegations of inappropriate placement, care, and treatment of children, and the failure to provide such care in the least restrictive setting.

Cases involving more than one state care system are so noted. In addition to alleged violations of major federal and state statutes which govern systems of services to children in state care, a number of these cases allege violations of P.L. 94-142, The Education for All Handicapped Children Act.

# TABLE OF CASES
# (BY STATE)

## ALABAMA

| | |
|---|---|
| J | Melvin P. v. Lauderdale County, No. CV-87-HM 5128-NW (D. Alabama, 1987) |
| M,C | R.C. v. Hornsby, Civ. Act. No. 88-D-1170-N (M.D. Ala., filed 1988); mot. to dismiss den. Apr. 19, 1989 |

## ARKANSAS

| | |
|---|---|
| C | R.T. v. Patterson, 87-2689 (Chancery Ct., Pulaski County Ark., filed June 3, 1987) |
| C | Harpole v. ARK:DNS, 820 F.2d 923 (8th Cir., 1987) |

## ARIZONA

| | |
|---|---|
| M,J | Johnson v. Upchurch, et al, No. CIV-86-195-TUC-RMB (D.Ariz., filed April 8, 1986) |
| J | Anthony C. v. Pima County, No. CIV 82-501-TUC-ACM (D. Arizona, 1986) |

## CALIFORNIA

| | |
|---|---|
| C | Gibson v. Merced County Department of Human Resources, 799 F. 2d 582 (9th Cir. 1986) |
| C | Hanson v. McMahon, 193 cal. App. 3d 283, Cal. Rptr. 232 (1987) |
| C | Timothy J. v. Chaffee, LASC #CA 001128, filed Aug. 26, 1988 |

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C = Child welfare case
J = Juvenile justice case
M = Mental health case

J Baumgartner v. City of Long Beach, Civil No. C 547482 (Cal. Superior Court, 1987)

J Bull v. California Youth Authority, Civil No. C-840052 (Cal. Superior Court, 1985)

J Hollingsworth v. Orange County, Case No. 51-08-65 (Cal. Superior Court, 1987)

J Hunt v. County of Los Angeles, Civil No. C-54783 (Cal. Superior Court, 1986)

J Jane G. v. Solano County, CIVS-81-0080 RAR (E.D. California, 1985)

J Nick O. v. Terhune, CIF 89-0755 RAR-JFM (E.D. California, 1989)

J Robbins v. Glenn County, No. CIVS-95-0675 RAR (E.D. California, 1985)

J Steven L. v. Kern County, CIV. ACTION No. CV-F-83-189-EDP (E.D. California, 1983)

C Maria G. v. McCarthy, CIV. NO. 333240 (Cal. Superior Court, 1985)

## COLORADO

J Weathers v. Leidig, Civil Action No. 80-M-1238 (D. Colorado, 1983)

## CONNECTICUT

C In Re Cynthia A., 514 A.2d 360 (Conn.App.1986)

## FLORIDA

J Bobby M. v. Martinez, CASE NO. TCA 83-7003 MMP (D. Florida, 1987)

| | |
|---|---|
| J | G.C. v. Coler, CASE NO. 87-6220-CIV-GONZALEZ (S.D. Florida, 1988) |

## GEORGIA

| | |
|---|---|
| C | J.J. v. Ledbetter a.k.a. J.J. v. Edwards, No. CV180-94 (S.D. Ga., filed May 12, 1980) |

## IDAHO

| | |
|---|---|
| J | Danny O. v. Bowman, NO. CIV 84-1272 (D. Idaho, 1985) |
| J | M.M.B. v. Bonneville County, CASE No. 86-4244 (D. Idaho, 1987) |
| J | John Doe v. Minidoka County, CIV. No. 87-1356 (D. Idaho, 1987) |
| J | Yellen v. Ada County, CIV 83-1026 (D. Idaho, 1985) |

## INDIANA

| | |
|---|---|
| M,J | C. v. Hughes, No. IP89 30C (S.D.Ind., filed Jan. 12, 1989) |

## ILLINOIS

| | |
|---|---|
| C | Aristotle P. v. Johnson, No. 88C7919 (N.D. Ill., filed Dec. 5, 1988) |
| C | Artist M. v. Johnson, No. 88C1050 (N.D. Ill., filed Dec. 14, 1988) |
| C | B.H. v. Johnson, No. 88C5599 (N.D. Ill., filed June 9, 1988) |
| C | Bates v. Johnson, No. 84-C-10054 (N.D. Ill., filed Nov. 20, 1984) |
| C | Burgos v. Ill. Department of Children and Family Services, No. 75 C 3974 (N.D. Ill., Nov. 1975) |

| | |
|---|---|
| C | Christina W. v. Johnson, No. 88C8383 (N.D. Ill., filed Sept. 30, 1988 |
| C | Doe v. Lambert, No. 8708150 (N.D. Ill., filed Sept. 21, 1987) |
| C | Eric P. v. Johnson, No. 88CH4588 (Cir. Ct. Ill., Chancery Div.), filed July 6, 1988 |
| C | Fields v. Johnson, No. 89C1624 (N.D. Ill., filed Feb. 27, 1989) |
| C | In Re Frank B., et al, No. 83J14375 (Cir. Ct. Cook, Ill, filed June 1, 1989) No. 89-1493 (Ill. Appellate Court, appeal filed June 4, 1989) |
| C | Hill v. Erickson, 88 Co. 296 (Cook Co. Ct., Ill. Cty. Department, Cty. Division (Mental Health) Jan. 12, 1989 |

## KENTUCKY

| | |
|---|---|
| C | Eugene D. v. Karman, No. C-84-1075-L-A (W.D.Ky., filed Oct. 17, 1984) |
| C | Timmy S. v. Stumbo, 537 F.Supp. 39 (E.D.Ky. 1981) |
| J | Horn v. Oldham County, Civil Action No. C 83-0208-L(B) (W.D. Kentucky, 1985) |
| J | Jesse James, et al v. Wilkenson, et al, Civil Action No. C-89-0139-P (CA) (D.Ken., filed June 12, 1989) |
| C | In Re Michael and Michelle P., Fam., Law Rpt. 2722; state court, Louisville, KY, 15 |

## LOUISIANA

| | |
|---|---|
| C | Del A. v. Edwards, Civ. Act. No. 86-0801 (E.D.La., Mot. to dism., March 2, 1988), aff'd 855 F.2d 1148 (5th Cir., 1988) vac. and en banc rev.gr. 862 F.2d 1148 (5th Cir., 1988) app.dism. 867 F.2d 842 (5th Cir., 1989) |

## MAINE

J Desrosiers v. Androscoggin County, Civ. No. 85-00091P (D. Maine, 1986)

J Eric P. v. Cumberland County, Docket No. CV-86-0265 P (D. Maine, 1988)

## MARYLAND

C L.J., et al v. Massinga, et al, 838 F.2d 118 (4th Cir., 1988), cert.den. 57 USLW 3453 (Jan. 9, 1989); Consent Decree approved 699 F.Supp. 508 (Md., 1988)

## MASSACHUSETTS

J Doe v. King, No. 37561 (Mass. Super. Ct. filed Sept. 24, 1979), No. 80-51 (Mass. Supreme Judicial Court Appeals Court)

J Lynch v. Dukakis, a.k.a. Lynch v. King, 550 T.Supp. 325 (Mass., 1982) aff'd 719 F.2d504 (1st Cir., 1983)

## MICHIGAN

J Committee to End Racism, Quinn v. Mansour, 85 CV7438DT (E.D. Mich, filed Sept. 23, 1985)

## MINNESOTA

C DOE v. Hennepin Co., 858 F.2d 1325 (8th Cir., 1988)

## MISSOURI

M,C G.L. v. Zumwalt, 564 F.Supp. 1030 (W.D.Mo., 1983)

J L.O. v. Honorable Ronald M. McKenzir, et al, No. 89-0025-C (E.D. Mo., filed Feb. 23, 1989

## NEW MEXICO

C Joseph and Josephine A.v. New Mexico Department of Human Services, 575 F. Supp.346 (N.M., 1983)

J Johnnie K. v. County of Curry, No. CV 81-0914-M (D. New Mexico, 1983)

J Johnnie K. v. Crist, No. CIV. 82-0182-HB (D. New Mexico, 1983)

## NEW YORK

C Baby Jennifer v. Koch, 86 Cir. 9676 (VLB, (S.D.NY., filed Dec. 18, 1956)

C Consentino v. Perales, No. 43236/85 (NY Sup.Ct., New York County, filed Nov. 7, 1985)

M,C Doe v. New York City Dept. of Social Services, 670 F.Supp. 1145 (S.D.N.Y., 1987)

C Eugene F. v. Gross, Index No. 1125/86 (Sup.Ct., N.Y.Co.)

C Grant v. Cuomo, 509 N.Y.S. 2d 685 9sup. Ct. 1986 (preliminary injunction); 518 N.Y.S. 2d 105 (A.D. 1st Dept., 1987); No. 349 (N.Y. Ct. App., Dec. 20,1988)

C Martin and Bill A. v. Gross, (Consolidated with Consentino v. Perales for disposition), 138 Misc.2d 212 (Sup. Ct. N.N.Co., N.Y., 1987)

C Palmer v. Cuomo, No. 2307/85, (Sup. Ct. N.Y., filed Jan. 18, 1985)

C Wilder v. Bernstein, 645 F Supp. 1292 (S.D.N.V. 1986) Af'd 848 F2d 1338 (end Cir., 1988)

C Jane B. v. New York City Dept. of Social Services, 87 Civ. 3114 (S.D.NY. Leisure, 1987)

C Grant v. Como, No. 349 (N.Y. Ct. of App.) Dec. 20, 1988)

J Schall v. Martin, 467 U.S. 253 (1984)

## NORTH CAROLINA

M,C Willie M. v. Hunt, CIVIL NO. CC 79-0294 (W.D. North Carolina, 1981)

## OHIO

J Doe v. Burwell, Civil Action No. C-1-81-415 (S.D. Ohio, 1982)

M,C Roe v. Staples, C-1-83-1704 (S.D.Ohio, Consent Decree entered Oct. 2, 1986)

## OKLAHOMA

J Terry D., et al, v. L.E. Rader, et al, No. Civ. 78-004T (W.D. Okla., filed January 4, 1978)

## OREGON

J Gary H. v. Hegstrom, CIVIL NO. 77-1039 (D. Oregon, 1985)

C Lipscomb v. Simmons, 884 F.2D 1242 (9th Cir., 1989)

## PENNSYLVANIA

C O'Dell v. Reeves a.k.a. O'Dell v. O'Bannon, No. 79-744, (E.D. Penn., filed March 2, 1979)

C Marilyn W. v. Children and Youth Services, No. 842 of 1984 (Fam. Div., Juv. Sect., Ct. Common Please, Allegheny Co., Pa., April 1989)

J T.B. v. Commonwealth, No. 1765, State Court of Pa., 1988

## SOUTH CAROLINA

J Robert K. v. Bell, Civil Action No. 83-287-0 (D. South Carolina, 1984)

## UTAH

J D.J.R. v. Christean, Civil No. C-82-0811W (D. Utah, Central Div., 1982)

J Milonas v. Williams, Civil NO. C-78-0352 (D. Utah, 1980)

## VERMONT

M,C Jane T. v. Morse, No. S-359-86 WNC (Vt. Superior Ct., Wash Co. filed Aug. 28, 1986)

C State of Vermont Department of Social and Rehabilitation Services v. United States Department of Health and Human Services, No. 84-325 (D.Vt. Mo for Summary Judgment, Aug. 28, 1985)

## WASHINGTON

J Aguilar v. Mitchell, No. C-77-254-JLQ (E.D. Washington, 1981)

J C.H. v. Girard, No. C87 522T (W.D. Wash., filed August 2, 1987)

J Tommy P. v. Board of County Commissioners, No. 224 974 (Superior Court, 1977)

## WASHINGTON, D.C.

J Jerry M. v. Barry, C.A. NO. 1519 (1985); Consent Decree entered 1986

C Clashawn A. v. Barry, No. 89CN1754, (D.D.C., June 20, 1989)

## WISCONSIN

C Deshaney v. Winnebago., 57 U.S.L.W. 4218 (Feb. 22, 1989)

# APPENDIX VI

## SURVEY: ADDICTED INFANTS AND THEIR MOTHERS

# ADDICTED INFANTS AND THEIR MOTHERS

*A SURVEY PREPARED AT THE REQUEST OF*
*CONGRESSMAN GEORGE MILLER, CHAIRMAN*
*SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES*
**Released April 27, 1989, at hearing entitled**
**"Born Hooked: Confronting the Impact of Perinatal Substance Abuse"**

## INTRODUCTION

Three years ago, the Select Committee on Children, Youth, and Families conducted a hearing on infants at risk due to parental addiction and disease. Since that time, it is apparent that there has been an explosion in the availability and use of illicit drugs, especially crack cocaine. To understand the scope of addictions among pregnant women and the effects on their children, I asked the staff of the Select Committee on Children, Youth, and Families to sample the experiences of major municipal hospitals around the country.

In response to my request, the staff conducted a telephone survey of 14 public and 4 private hospitals in 15 cities, including 9 of the most populous cities. (Cities in which hospitals were surveyed include: Boston, Chicago, Dallas, Denver, Detroit, Houston, Los Angeles, Miami, New York City, Oakland, Philadelphia, Phoenix, San Antonio, Seattle and the District of Columbia.) Interviews with obstetricians and gynecologists, neonatologists, social workers and administrators in one or two hospitals in each of these cities provided the basis for our observations. While the study is by no means definitive, nor is the sample scientific, the findings which emerge offer a snapshot of the prevalence and impact of drug addiction on pregnant women and their newborn infants.

The survey questions centered on trends in births of drug-exposed infants, whether and how infants and/or pregnant women are screened for illegal substances, length of hospital stay, and costs associated with substance-exposed infants. Staff requested data on the following illegal substances individually or in combination: cocaine, heroin, PCP, marijuana, or any other measured. Although the survey focused principally on illegal drug abuse, experts agree that alcohol and/or tobacco use often accompany other drug use and pose serious risks of poor birth outcomes. Data provided on alcohol and/or tobacco use were also recorded.

While the newness of the problems, their rapid increase, and lack of uniform data prevent our obtaining a precise count of drug-exposed births, the experiences of hospital staff are undeniably and remarkably comparable -- and their observations and concerns are similar on several points.

## PRINCIPAL FINDINGS

### TRENDS IN BIRTHS OF DRUG-EXPOSED INFANTS

1. **Of the 18 hospitals surveyed, 15 (14 public and 1 private) reported an increase in the incidence of substance abuse during pregnancy and the number of drug-exposed births since 1985. (See Notes 1a, b, c.)**

   **Eight hospitals surveyed had trend data available:**

   - A hospital in **Dallas**: based on maternal histories, the number of drug-exposed newborns increased from 65 of approximately 3,410 total births to 192 of 3,360 total births between 10-12/1987 and 10-12/1988.

   - A hospital in **Denver**: based on maternal histories, the number of drug-exposed newborns increased from 32 of 2,875 total births to 115 of 2,924 total births between 1985 and 1988.

   - A hospital in **New York City**: based on newborn toxic screening, the number of drug-exposed newborns increased from 12%-13% of 2,900-3,000 total births in 1985 to 15% of 2,900-3,000 total births in 1988.

   - A hospital in **Oakland**: based on newborn toxic screening, the number of drug-exposed newborns increased from 6% to 18% of the approximate 2,400 total births per year between 1985 and 1988.

- A hospital in **Philadelphia**: based on newborn toxic screening and maternal histories, the number of drug-exposed newborns increased from 4% of approximately 1,078 total births in the period 7/1/87-12/31/87 to 15% of 1,105 total births in the period 7/1/88-12/31/88.

- A hospital in **Washington, DC**: based on newborn screening and maternal histories, the number of drug-exposed newborns increased from 5.7% of 1,994 total births in 1985 to 18% of 1,812 total births in 1988.

- A hospital in **Detroit**: based on maternal histories, the number of narcotics-exposed infants (which primarily reflects maternal cocaine use and, to a much lesser degree, heroin use) increased from 9.1% of 1,111 total clinic births in 1985 to 10.4% of 1,781 total clinic births in 1987.

- A hospital in **Houston**: based on maternal histories, the rate of drug-exposed infants admitted to the neonatal intensive care unit has increased from 1.73/100 to 4.9/100 between 7/1/86-6/30/87 and 7/1/87-6/30/88.

2. **Of the 18 hospitals surveyed, 9 suggested that the numbers of drug-exposed infants and substance-abusing pregnant women were undercounted.** According to these hospitals, the undercount can be attributed to maternal denial of drug use, lack of clinician sensitivity to indicators of drug use, and the inaccuracy of toxic screening which has high false negatives and only detects substance use within the previous 24 hours.

   - In a Miami prevalence study, only 27% of the pregnant women testing positive for drug use at labor and delivery had admitted drug use. (See Note 2)

   - A pediatrician in a Detroit hospital reported that urine toxicologies only detect 37% of the positive drugexposures because of the test's high rate of false negative.

3. **Hospital neonatologists and pediatricians cited similar physical and behavioral conditions of drug-exposed newborns: prematurity, low birthweight, hypertonicity, and low Apgar scores are frequent characteristics among newborns born to mothers who used drugs during pregnancy.** (Survey data received may reflect single or polydrug assessment.)

    o Hospitals in Detroit and Miami reported that approximately 1/3 of drug-abusing pregnant women had premature newborns. (See Note 2.)

    o A Washington, DC, hospital reported that 18% of its drug-exposed newborns had low birthweight, as compared to 12% of the non-exposed newborns.

## TRENDS AMONG SUBSTANCE ABUSING PREGNANT WOMEN

4. **Hospitals commonly found that substance-abusing pregnant women frequently suffered abruptio placenta and unexplained hypertension. Two hospitals reported maternal death during labor and delivery.**

    o A Los Angeles hospital reported that 3 maternal deaths in 1988 were attributed to drug ingestion.

    o A hospital in Washington, DC, reported the reemergence of maternal death associated with labor and delivery as a result of "crack" cocaine use.

5. **Four of the 18 hospitals surveyed stated concern about the increase in cases of venereal disease and increased risk of HIV infection among their patients, many of whom are substance-abusing women.**

    o A prevalence study of newborn drug-exposure at a New York hospital found a 495% increase in the number of reported syphilis cases among women between 1985 and 1988.

- o Several hospitals mentioned concerns regarding the risk to drug-exposed newborns of becoming HIV-infected because of the prevalence of the virus among intravenous drug users.

6. **Most of the hospitals surveyed reported that since 1980 "crack" cocaine has become the drug of choice.**

- o A hospital in Oakland reported that 90% of newborns with positive toxic screens showed cocaine exposure.

- o In a Houston hospital, the percentage of pregnant substance abusers reporting cocaine use increased from 2% in 1980 to more than 80% in 1989.

- o A Chicago two-week prevalence study found that, at labor and delivery, 55% of the women reporting drug abuse used cocaine.

7. **Respondents from several hospitals mentioned that alcohol consumption is a significant part of the polydrug pattern of substance abuse among pregnant women.**

- o Based on maternal histories, a hospital in Detroit found that 11.5% of births over several months in 1988 were to women who reported alcohol consumption during pregnancy.

## HEALTH CARE FOR ADDICTED PREGNANT WOMEN

8. **Seven of the 18 hospitals surveyed reported that substance-abusing pregnant women were up to four times less likely to receive prenatal care than other women.**

- o According to a responding obstetrician at a Miami hospital, 30% of substance-abusing women do not obtain prenatal care compared with 15% of other women.

- A Dallas hospital reported that 50%-70% of substance abusing pregnant women do not receive prenatal care compared with 15% of other women.

9. **Twelve of the 18 hospitals surveyed reported that they have no place to send pregnant women for drug treatment.**

   - For pregnant women addicted to cocaine in Boston, there are approximately 30 residential treatment slots in the city. At a hospital in Boston, according to maternal histories, 18% of the 1,700 mothers delivering there use cocaine.

   - A hospital in Los Angeles noted a 10 to 16 week waiting period for drug treatment, even for pregnant women.

## PLACEMENT OF DRUG-EXPOSED INFANTS

10. **Eight of the 18 hospitals surveyed reported that drug-exposed newborns medically cleared for discharge regularly remain in the hospital for various reasons including the lack of available and appropriate foster care placement or delayed protective services evaluation.**

    - On a given day, a Miami hospital houses 20-30 "boarder" babies who may remain in the hospital for up to a month. The hospital attributed the high number, in part, to the effect of new state law which places all drug-exposed newborns under state custody, overwhelming the foster care system.

## HOSPITAL COSTS

11. **Although no cost studies specific to drug-exposed babies have been conducted, 8 of the 18 hospitals surveyed referred**

**to the high cost of care for low birthweight and sick babies, an increasing number of whom have been exposed to drugs. Often born prematurely or suffering withdrawal symptoms, drug-exposed newborns typically have longer stays in the hospital, frequently in the intensive care nursery (ICN).**

- o A Los Angeles hospital estimated the average cost of a drug-exposed newborn in the ICN is approximately $750/day for a mildly drug-exposed newborn and $1,768/day for a severely affected infant.

- o Eight of the 18 hospitals estimated that cocaine-exposed newborns also tended to stay 1 to 13 days longer than healthy newborns, though not in special care.

12. **Six of the 18 hospitals mentioned a lack of resources to confront the problem of drug-exposed newborns.** They cite the costs associated with drug screening, prevalence studies and "boarder" babies.

## NOTES

1.a. None of the 18 hospitals surveyed reported routinely screening all newborns or pregnant women for drug exposure. Fifteen of the 18 hospitals surveyed screen newborns if there are reasons to suspect drug-exposure, based on maternal history or report, or clinical signs. Eight of the 18 hospitals surveyed screen pregnant women if there are reasons to suspect drug abuse.

b. There is no uniformity in drug screening or data collection. That is, the way in which hospitals assess drug use and the resulting data bases vary hospital to hospital. This is to some extent due to the lack of adequate research protocols or agreement among medical and other experts as to the nature, appropriateness and consequences of such screening and/or reporting.

For example, 4 of the 9 hospitals which reported undercounting the numbers of drug-exposed newborns and/or substance-abusing pregnant women, showed a marked increase in the number of drug-exposed newborns simultaneous to hospital efforts to maintain data.

c. Three of the 4 private hospitals surveyed (Miami, San Francisco, Seattle) did not have data on drug-exposed newborns or substance-abusing mothers. None of these 3 reported an incidence of drug-exposed newborns over 2%. The hospitals said that the substance-abusing women primarily attended the area public hospital, except in emergency cases. The obstetricians and neonatologists explained that they did not routinely inquire about drug use when taking maternal history.

2. Bandstra, E.S., Steele, B.W., Burkett, G.T., Palow, D.C., Levandoski, N., and Rodriguez, V. "Prevalence of Perinatal Cocaine Exposure in an Urban Multi-ethnic Population." Pediatr Res, April, 1989 (In press).

## ADDITIONAL VIEWS OF HON. GEORGE MILLER, CHAIRMAN; HON. WILLIAM LEHMAN; HON. PATRICIA SCHROEDER; HON. LINDY BOGGS; HON. MATTHEW F. McHUGH; HON. TED WEISS; HON. BERYL ANTHONY, JR.; HON. BARBARA BOXER; HON. SANDER M. LEVIN; HON. BRUCE A. MORRISON; HON. J. ROY ROWLAND; HON. GERRY SIKORSKI; HON. ALAN WHEAT; HON. MATTHEW G. MARTINEZ; HON. LANE EVANS; HON. RICHARD J. DURBIN; HON. DAVID E. SKAGGS; AND HON. BILL SARPALIUS

The Minority is understandably concerned with the quality of data on out-of-home placements for children. As we have learned in seven years of work with researchers, social service professionals, and state administrators, the data are, indeed, inconsistent and incomplete.

However, it is important to note that experts and front-line workers suggest that, rather than overestimating the number of children in state care, available data in fact underestimate the magnitude of this crisis.

We concur if the Minority's suggestion is to improve data collection on out-of home placements. But we differ sharply from that point forward. Where the Minority's dissent implies that the federal government continue business as usual because it supposedly lacks sufficient information, we insist that enough is known to begin acting now.

In this report, the Committee has assembled evidence from federal, state and local administrators, social services workers, parents, foster parents, researchers and advocates, as well as the most reliable and comprehensive national data available. In the last several years the data for each out-of-home placement system are consistent in demonstrating a pattern of rapidly increasing numbers of children in placement. An estimated 500,000 children are now in out-of-home placement.

Unfortunately, as the Select Committee's most recent bipartisan report, "U.S. Children and Their Families: Current Conditions and Recent Trends, 1989," amply demonstrates, there is no evidence that the economic, demographic and social changes driving these placements - poverty, drugs, child abuse, and homelessness, among others - will lessen or reverse themselves any time soon. Furthermore, while selected states and communities are initiating promising efforts to address these problems, no new systemic policies to prevent unnecessary placement lie on the immediate horizon.

Looking carefully at what the best and most reliable current trend data suggest about future placements is essential if we are to shape policies appropriate to addressing them.

In the child welfare system, the available data indicate a decline in the number of children in foster care beginning in the late 1970s and lasting through the early 1980s, largely as a result of the development and passage of major foster care reform legislation (The Child Welfare and Adoption Assistance Act of 1980, P.L. 96-272). Since about 1983, the data show increases in the number of children placed.

In the juvenile justice system, the number of children in custody has grown steadily since 1979. This year recorded the lowest total number of children held in public and private facilities since 1975, the first time comparable data became available from the Department of Justice's Children in Custody Census.

National data on child placement in mental health facilities were only available for 1983 and 1986, and showed a substantial growth during that time. Since then, the number of children placed in the mental health system has reportedly continued to increase, possibly at an even greater rate.

These current patterns are very troubling. What they portend for the future if the trends continue unabated is even more disturbing. We sought in this report to determine what the future might look like under these conditions. With the assistance of Dr. Charles Gershenson of the Center for the Study of Social Policy, the Select Committee has estimated, using linear forecasting, that more that 840,000 children could be in out-of-home care by 1995 - if current trends continue, and absent effective countervailing policies.

The Minority quarrels with our methodology and the resulting projection. They charge overestimation, say the situation won't get that bad, and conclude that our projection will cause dismissal of the report and the problems it documents.

We disagree.

Let us examine the methodological issues raised:

- It is argued that any and all data from all years should have been used in making projections regardless of disparate patterns or number of years included in the data sets. However, the projection made in this report is based on the clearly stated assumption, "if current trends continue." The current trends inarguably show rising rates of increase in the numbers of children in out-of-home placement for each system examined.

  The projection is also based on the broadest, most reliable and most comparable data bases available. As noted throughout the report, researchers and those with front-line experience in the child welfare and mental health systems have pointed out repeatedly that the available data actually underestimate the numbers of children placed out of home today.

- In the area of child welfare, it is charged that the projection should have been based on calculations using 1980-1988 data, and that the Committee arbitrarily used 1985-1988 data. Our data were chosen for the following good reasons: National data are gathered through a voluntary system which began after 1980, and is operated by the American Public Welfare Association. These data are issued by the U.S. Department of Health and Human Services.

  From 1980, traditionally cited as the benchmark for the voluntary national system, through the early 1980s, the number of children in care reportedly declined. The trend reversed in the middle 1980s and has continued in this direction throughout the rest of the decade. Nationally published data do exist for 1983, 1984 and 1985. However, experts in the field consider data before 1985 very problematic. As a result, 1985 data were judged to provide the most valid basis for estimation.

- Some take further issue with the 1986-1988 child welfare data, because they are based on the experiences of only 11 states. However, these include the 10 most populous states in the nation where more than half of the total U.S. foster care population resides. Furthermore, a subsequent telephone survey of all 50 states conducted by Dr. Gershenson, and cross-validated with state foster care financial reports submitted to the Department of Health and Human Services, placed the Committee's 11-state estimate within 5% of the estimate for all 50 states.

  It is also charged that the child welfare data from 1986-88 are driven by California, and that if California were excluded from consideration, then the national picture would look brighter. In fact, however, as of 1985, California was home to more than 11% of the nation's children, and 16% of those in in foster care. Estimates which exclude this group would be both faulty and misleading.

- In the area of juvenile justice, it has also been charged that the Committee has not used all the available data. While data are available from 1975-1987, the "current trend" of increasing numbers of children in custody began in 1979. For the juvenile justice system, two estimates were made, one utilizing 1979-87 data (covering the longest period illustrating the current trend), the other utilizing 1985-1987 data (at the request of Select Committee Minority staff to make the years used to make the projections more comparable across the systems). However, the estimate of the number of children in custody in 1995 based on the shorter time span produced a much higher projection than that based on the longer time span. Thus, to be conservative in our estimates, and in consideration of the Minority's other data concerns, we used the lower projection.

The facts presented in this report are dramatic and far from encouraging. We sincerely hope that conditions change so that out-of-home placements will fall far short of those projected.

While we may quibble over absolute numbers, however, it is impossible to walk away from the primary findings of this report: the circumstances bringing children and their families into all three care systems have deteriorated substantially during this decade; services to prevent unnecessary placement, or to assist children and families where removal is necessary, are desparately lacking or inadequate; the agencies responsible are increasingly unable to cope with the complex needs of a rapidly growing population of vulnerable children and families; and there has been a serious absence of meaningful oversight or accountability by government at all levels resulting in the virtual abandonment of protections and safeguards that children and families are assured by law.

We hope that this report will spur action to improve both what we know about children in out-of-home placement and what we do. The need to prevent unnecessary removal and to intervene more effectively by providing a continuum of services - to enable families to care for their children, and ensure children safe and permanent homes - has never been clearer or more urgent.

**(Signed)**

GEORGE MILLER,
Chairman
WILLIAM LEHMAN
PATRICIA SCHROEDER
LINDY (MRS. HALE) BOGGS
MATTHEW F. McHUGH
TED WEISS
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# No Place To Call Home: Discarded Children in America
## Dissenting Views

The increase in children placed in the care of the state is a reflection of what is happening in our society--the devaluation of human life. The report is an admission that even with dedicated professionals working in the social welfare system, some families cannot withstand the hurricane force waves of abuse, drugs, sexual exploitation, and violence which have unleased their destruction on society. Thus, this report is a challenge to us all.

This report "from the front" paints a Dickens-like picture of children in state care who are "traumatized" by the very systems designed to help them. But to assume that the Select Committee report can be relied upon to help make policy would be a mistake. The anecdotes presented here are not a substitute for basic national information about what the state and locals are doing in child welfare. This information, while dramatic, and in some cases, overly dramatic, might help us describe the problem, but gives us little direction as to appropriate policy responses.

As we consider this report, we must be careful in the way we describe our children in substitute care. The child is always the victim and we must not punish that child further through stigma and disrespect. Foster children and their foster parents should be held in a special place of esteem by us all. Tradition tells us that the three most important men in Judeo-Christian and Moslem history each had a foster parent. Thus, let us renew our commitment to these children by affirming the intrinsic value and dignity of each human life, regardless of physical and mental condition or state of dependency.

### Problems With Projections

While we agree that the growing numbers of children in substitute care concern us all, we strongly reject the projected data the Majority would have us adopt. We cannot agree with the "finding" that "out-of-home placement" will increase by over 70 percent to more than 840,000 children.

In calculating this figure, the Majority has simply disregarded the data which do not fit into their preconceived notion. For example:

- The chart on Foster Care Trends on page 10A provides data from 1980. It clearly shows a decline from 1980 to 1985. The figures for 1986 were still below 1980. But instead of using all of the data, the majority simply ignored that information. Using all of the data, including 1980 to 1985 would have still given us a projected increase, but at a much more modest and reasonable rate.
- Choosing which year of data to begin with is significant. By excluding 1980, the majority projects a 7.2 percent annual increase in foster care children to 1995. But if we included 1980, we would find a 1.5 percent rate of increase. Obviously, the number of children projected to be in foster care would be much lower.
- From 1975 to 1979, there was a decline in the number of juveniles in custody. Although the Chart on 10B, "Total Juveniles in Custody," provides this data, the majority has simply ignored it in making their projection.
- The projections are based on a survey conducted by the majority staff. According to the majority's own data, only 3 of the 11 states experienced an increase in the foster care population between 1980 and 1988. This should tell us that it is difficult to generalize what has happened in those states to the rest of the country.
- The conclusions of the majority survey appear to be driven by one state, California. If California is excluded from consideration, we find that there was a 22 percent decline in the number of foster care children between 1980 and 1985, and a 15 percent increase between 1985 and 1988, compared to the 9 percent decline and 23 percent increase when California is included.

Although we have tried to reach agreement on the use of caseload numbers, the majority has rejected our concerns and insists on forcing us to accept what we consider to be fatally flawed numbers. Our concern is that the numbers are so unreliable that the message will be dismissed. We believe that just one child in foster care is too many. Foster care is always meant to be temporary, to bridge a gap until the family in crisis has been mended. But it is misleading to provide the rest of Congress, in our role as a select committee, with information which is biased and which will serve only to sensationalize the condition of these systems.

## Federal/State Responsibility

While the report faults the federal government for weak compliance standards, the facts are that, as weak as they are, the states have not been able to comply even with these admittedly weak guidelines.

Ten years after the enactment of federal legislation designed to provide protections for children in out-of-home care, we find that we still don't know how many children are in care; how many are waiting to be adopted; how many have realistic goals of going back home, etc. Clearly, additional nation-wide information on adoption and foster care is needed.

Republican members of the Select Committee on Children, Youth, and Families have ordered four different GAO reports, which provide convincing evidence that at present the procedures and protections put in place by the federal government to protect children have not been implemented by the states. (Foster Care: Preliminary Report on Reform Effects, U.S. General Accounting Office, June 1989; Foster Care: Incomplete Implementation of the Reforms and Unknown Effectiveness, U.S. GAO, August 1989; Foster Care: Delayed Follow-up of Noncomplying States May Reduce Incentive for Reform, U.S. GAO, August 1989; and Foster Parents: Recruiting and Preservice Training Practices Need Evaluation, U.S. GAO, August 1989.)

In one Republican-ordered GAO study, it is noted that we need to go beyond the numbers of children in placement and obtain data on both the intended and unintended consequences of federal reforms on the quality of care which children in state care receive. Without such information, it is impossible to legislate in this area. How can federal officials provide oversight when basic information on the effect of the reforms is inadequate and seriously flawed? GAO reports "oversight of the reforms requires current, national information about state and local agency behavior as well as the outcomes for children in foster care, yet such information was generally unavailable...". (Foster Care: Incomplete Implementation of the Reforms and Unknown Effectiveness, U.S. GAO, August 1989, p. 4-5)

## Drugs Driving Increase in Out-of-Home Placements

Although the Committee Republicans disagree with the size of the increase in out-of-home placements based on a ten-state survey, we are in complete agreement that an increase of some proportion is happening. There is no question that drug-related behaviors are driving the increase in out-of-home placements. Questions abound, however, in terms of appropriate policy response.

Traditionally, the child welfare system has only reluctantly considered termination of parental rights. With increasing recognition of the effects of parental drug abuse on children, coupled with high rates of recidivism among patients in drug treatment centers, doubts are raised about the extent to which permanent placement plans can be made for children of substance abusers without increased attention to adoption options.

## Family Demographics--Changes in Family Structure

The rise in out-of-home placements is also certainly related to the devastating trend since 1970 toward family dissolution. These statistics from a recent Census Bureau study underscore this point: "Between 1970 and 1988, the number of single-parent situations more than doubled from 3.8 million to 9.4 million. The dramatic rise in one-parent situations is also shown by their increase as a proportion of all family groups with children; this proportion has more than doubled from 13% in 1970 to 27% in 1988." (Census Bureau, Series P-23, No. 162, Studies in Marriage and the Family, p. 14.)

## Child Abuse

While the number of child abuse allegations continues to climb, the Republicans hesitate to equate this increase with a rise in the number of incidents. In our 1986 Dissenting Views to "Abused Children in America: Victims of Official Neglect," we noted that a link between reports and incidents has not been confirmed. We cited a study by the American Humane Association that stated, "what is not possible to propose is that there is a direct correlation between reporting rates and actual incidences of maltreatment." (p. 336)

The report also refers to a 1988 Department of Health and Human Services Incidence Study that "document(s) a 64% increase over 1980 in the number of children reported." However, the Select Committee report fails to include an interpretation of this increase, provided in the same study: "The NIS-2 Study (1988) indicates that the increase in incidence of child abuse and neglect between 1980 and 1986 is probably due more to an increase in the recognition of child maltreatment by community professionals than it is due to an increase in the actual occurrence of maltreatment." (p. XV)

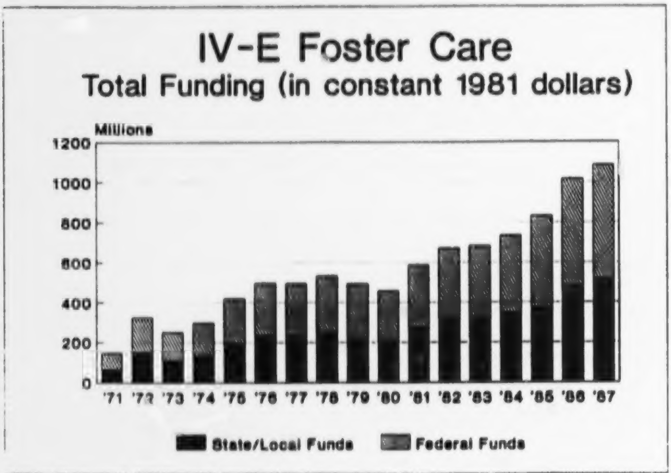
Contributing to the confusion surrounding the interpretation of child abuse numbers are the following factors: each state defines child abuse, neglect and sexual abuse differently; and there are different reportable conditions. Thus, the wide variance in definitions makes any across-state or nationwide data less meaningful.

## Homelessness

Homelessness does place children at increased risk for substitute care. The numbers that estimate the size of the problem, however, should be read with caution. "About 70% of the clients in shelters serving primarily families with children had been homeless for less than three months. Thirty-eight percent of the clients in shelters serving predominantly men were reported to have been homeless for more than three years." (U.S. Department of Housing and Urban Development, A Report on The 1988 National Survey of Shelters for the Homeless, March 1989, p. 15) While it is estimated that the proportion of shelter-using homeless who are family members has increased, clearly, the length of homelessness is much shorter for family members than for single men. No family in America ought to be without a "place to call home;" the tragedy lies not with the spirit of the American people reflected in government policies, but in the tragic breakdown of human relationships.

## Funding

The rhetoric of the majority on support for child welfare programs sometimes does not match reality. Our federal, state, and local governments indeed provide many forms of assistance to our children in foster care. The funding for the Title IV-E Foster Care program has increased in constant dollar terms every year since 1980 and now totals nearly $1.1 billion. In addition, many foster care children are eligible for Medicaid.



IV-E Foster Care
Total Funding (in constant 1981 dollars)

Source: ACYF, DHHS; Background Material and Data on Programs within the Jurisdiction of the Committee on Ways and Means, 1989. Conversion to constant dollars based on 1990 Budget Implicit Price Deflators for Composition of Total Outlays, OMB, January 1989.

We must also disagree that the macroeconomic policies of the 1980s have played a significant role in the increases in these programs. The numbers of people in poverty are related more to behavior than to our general economic condition. Certain behavior unquestionably may result in both social and economic poverty, but it is an affront to the dignity of many Americans to imply that being "poor" under a government definition of economic status is prima facie evidence of being a child abuser or spouse abuser or drug user.

## The Challenge for the 1990s

The pressures of a materialistic, "have it all, have it now" society can threaten families. The question of the times is, "can we master the technological age while keeping our values intact in today's world?" It is a challenge to the "mediating structures" in our society, including churches, to recognize that physical abuse is a sign of spirituality in crisis. The children who have been abandoned by their parents must be assured that they have not been abandoned by the extended family of our society.

(Signed)

THOMAS J. BLILEY, JR.
Ranking Minority Member
FRANK R. WOLF
BARBARA VUCANOVICH
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